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# **Canadian Psychiatric Association Journal**

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**October 1960**

## **La Revue de l'Association Canadienne de Psychiatrie**



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## Editorial

### STATUTORY PRIVILEGE OR OPEN SECRET

The confidential nature of the transactions pertaining to psychiatric treatment is so intimately related with the latter's successful outcome that it is not questioned by either of the parties involved.

The psychiatrist is bound, even more so than any other member of the medical profession, by the Hippocratic Oath: "Whatsoever I shall see or hear in the course of my practice or outside my practice in the life of men, that ought not to be spoken abroad, I will not divulge, holding such things to be holy secrets". Only a demented person could be expected to confide his most private thoughts without the assurance that they will never be disclosed.

Fortunately, patients are not properly informed of the flimsiness of the implicit or expressed promise made by the psychiatrist in exchange for the sincerity and truth he requires from them. It is also fortunate that the same ignorance is shared by the psychiatrist, for his own peace of mind and ability to work.

The psychiatrist's ethical obligations of confidentiality to his patients are illusory, since their implementation would require the sanction of legal privilege, which is denied to the medical profession of our country. In Canada, only lawyers are entitled without restriction to refuse information about a client on the ground that it constitutes a "privileged communication".

Quebec, which is not ruled by common law, is the sole province that grants partial medical privilege. Its Medical Act provides that "no physician may be compelled to declare what has been revealed to him in his professional character". But it has been held in court that "the physician is the arbiter of what he should, or should not say". Furthermore, this law applies only to civil cases, criminal matters remaining under the jurisdiction of Parliament.

There is more than a purely academic interest in the discussion of medical privilege. A psychiatrist of Chicago faced contempt of court in 1952 by refusing to testify in a divorce action. He could have been forced to disclose information, obtained during psychiatric treatment, concerning his patient. According to an eminent Canadian authority on forensic psychiatry, "our courts would hold such communications were not privileged and would require a psychiatrist to testify."

A psychiatrist is subjected to being subpoenaed as a witness for or against his patient and "must answer all relevant questions, when he is giving evidence. He cannot refuse to answer on the ground that he would be betraying the confidence of a patient". If the subpoena is served in the form of a *duces tecum*, he may be compelled to produce all relevant files, correspondence, notes and recordings. *Dura lex, sed lex*.

For more than twenty-three centuries, the medical profession has proclaimed the inviolability of confidences imparted by a patient to his physician. This right of the patient is explicitly recognized by many civilized and democratic countries.

The French *Code pénal* punishes breaches of professional secrecy with a fine and a sentence of imprisonment. In 1828, the State of New York enacted a statute protecting the communications of patients to their physicians. Forty jurisdictions in the U.S.A. have now legalized medical privilege, and, in 1959, a State legislature specifically granted this privilege to patients "undergoing psychiatric treatment". In eight States, the same privilege as exists between lawyer and client has been extended to psychologists.

In Canada, all provinces lack adequate legislation on privilege in civil cases. The *Criminal Code* provides no protection in criminal proceedings. By defining the confidential relationship and communication between physician or psychiatrist and patient on the same basis as it exists between an attorney and his client, and by making the breach of such privilege an indictable offence, the Parliament of Canada would immediately safeguard the basic right of each citizen to the complete privacy and trust which are essential to a therapeutic doctor-patient relationship.

In our age of anonymous and mechanized efficiency, a measure which would uphold and sanction the claim of the sick to be treated with respect, would restore some of the lost dignity of man. It would also remind us of our duties to our patients.

One should hope that a restraining influence would thus be exercised on the prevalent type of loose professional gossip between psychiatrists at scientific meetings, in hospital wards and dining rooms. An optimist could anticipate the subsidence of the careless shop talk of psychiatrists in social gatherings and private drawing rooms. Perhaps a greater number of psychiatrists would be led to commit their relatives, children, wives, or even themselves, to a colleague's care for needed treatment, which is often neglected for more or less conscious and justified fears of having one's dirty linen washed in public.

A patient should always enjoy the full rights of unqualified medical secrecy, and especially the psychiatric patient—not because psychiatric illness is still regarded with suspicion in some quarters, but because he is entitled to the same unconditional and unlimited trust as is required from him by the psychiatrist for the fulfilment of their common therapeutic aims.

J. B. B.

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## AN EXAMINATION OF THE CONCEPT OF MILIEU THERAPY\*

WM. E. POWLES, M.D.<sup>1</sup>

It would be presumptuous and probably idle to suggest that there is either a unitary concept or a clearly agreed dynamic of milieu therapy. This term has gained great popularity in the past ten years, but its meanings are probably nearly as numerous as the people who use it.

Since long before Pinel's day, startling modifications in hospital milieu have in turn been proposed, tried, and gone out of fashion. Aichhorn<sup>1</sup> was perhaps the first modern to apply psychiatric knowledge to the institutional environment. In a school for delinquent teenagers, such was the success of his philosophy of human reconciliation, that no obscene writings were found in the toilets! More recently, Bettelheim<sup>2</sup> can be given credit for the notion of the "therapeutic milieu", or "milieu-psychotherapy", as such. His principal distinction has been between the "Institutional" type of milieu, with all that is impersonal and regimented in it, and the "Therapeutic" milieu, where staff and patients are real people with real identities and real relationships. Bettelheim, working with schizophrenic children, portrays the changes occurring in the patient who moves from an institutional to a therapeutic milieu, where (from an individualized position previously denied by stereotyped institutional management methods) he can at last make progress in adjustment. Leone<sup>3</sup> has drawn attention to the loss of individuality and the favoritism which can occur in medical wards, and to techniques of re-personalizing the patient who has become a "case". This "therapeutic" or personalistic frame of reference may be considered as the first of three dimensions within which to view milieu therapy.

Stanton and Schwartz<sup>4</sup>, and Caudill<sup>5</sup>, have made helpful contributions to an understanding of hospitals as human communities: how so much that is informal and unofficial in their operation is of greatest importance; how communication and honest decision making are vital but difficult to achieve; how staff and patients really form parts of an integrated system, with staff having needs as well as patients; and how even very sick people can, and must, help each other in recovery. This organismic view of the hospital may be seen as a second dimension contributed to our thinking.

"Therapeutic community" is a term coined by Main<sup>6</sup> and more popularly associated with the work of Jones<sup>6</sup>. It is the somewhat one-sided and aseptic connotations of "milieu therapy" which are attacked in the views of Main and Jones. Appropriate enough in the children's setting which Bettelheim reports, the view of staff as benign, giving, managing and treating patients who are confused, passive, regressed, and in a recipient role is too rigidly modelled upon traditional medical and surgical treatment, and is inappropriate in the effort to assist toward recovery the adult psychiatric patient in whom flight from conflict and from interpersonal and intrapsychic difficulties are at the centre of the illness. The idea of therapeutic community urges that activity and responsibility on the part of patients, and an energetic interaction between patients and staff, be placed at the centre of treatment philosophy. This may be seen as our third dimension. A synthesis of the personalistic and organismic views, the therapeutic community view offers extended possibilities for the development of treatment milieus in which staff and patients *work together*.

\*Presented at the annual meeting, Canadian Psychiatric Association, Ottawa, June, 1959.

<sup>1</sup>Department of Psychiatry, University of Cincinnati.

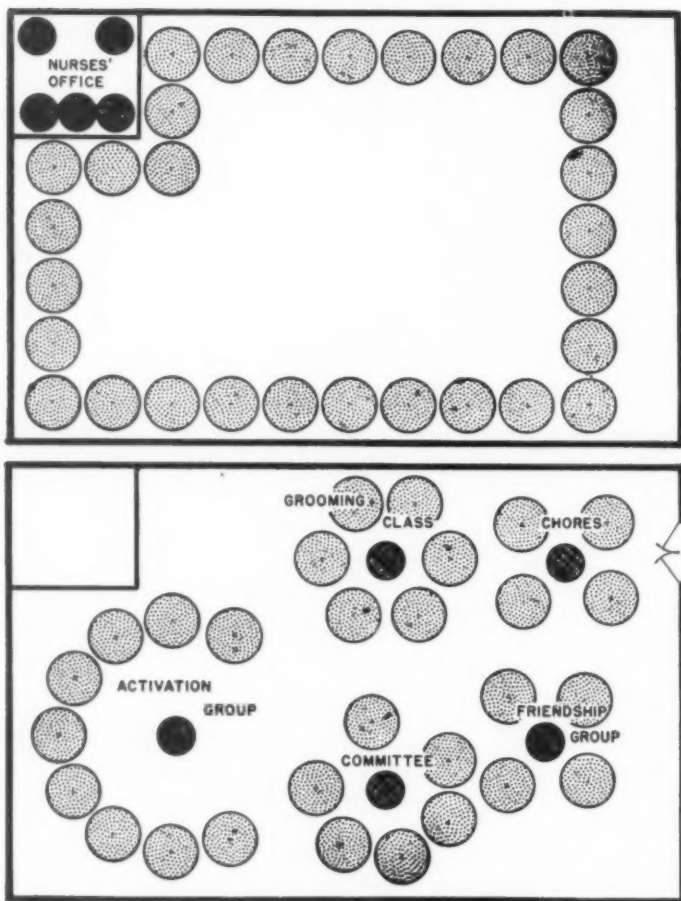


Fig. 1. Representation of a 180-bed female chronic psychiatric ward. Above, a closed institutional or custodial pattern, the patients lining the walls of the day room, and the staff in their office. Below, a more therapeutic pattern, the staff and patients interacting in group activities, with ward doors unlocked.

Rashkis<sup>9</sup> recommends that we practice a principle which we already recognize, namely, that many ill people, from acute psychotics to those with acute ulcers, are known to do well on purely nonspecific hospital management. His implication is clear, that a planful, rather than chance, use of hospital milieu will in itself result in a high rate of cure, or at least satisfactory remission.

The intelligible unit of milieu or community is surely for most of our purposes the hospital ward, a group of staff and patients living together in some continuing interpersonal pattern. It is proposed here to examine the structure of three actual psychiatric wards: a chronic custodial ward; a day hospital; and a closed admitting ward. Figure 1 depicts an old-style chronic custodial ward of 180 female beds. As the upper diagram suggests, one often saw the staff secluded in a corner office, while patients sat, stood, or moved about the day

room in a random and somewhat centrifugal pattern. At meal time, at work time, and at bed time a silent and apathetic line of patients was herded by silent attendants to the kitchen, laundry, sewing shop, or dormitory. This community, if it can be called such, was surely a barren and unsatisfying one indeed. The staff, many of them fine women, tended to be discouraged, detached, hardened, and even punitive; they applied the prescribed routines faithfully but without much cheer or personal affection. Perhaps they knew a few of the more distinctive patients in the sense that they called them by distinctive nicknames. These likely possessed social skills such as piano playing or ability to discern the staff's whims. The large residue of patients, submerged in an impersonal timetable of activities, and unable to initiate any stable relationship with any staff person, suffered progressive depersonalization, withdrawal, and dumb dependency on the institution, which first complicated, and then often supplanted, their original clinical illness. In such a milieu, the use of locked doors, seclusion, and restraints, of medication and shock therapies and other such impersonal agents, tended to be high.

The serious question arises, of course, as to whether a ward of 180 people can ever be a therapeutic community. The author personally has grave doubts that it can. However, we have learned of profitable changes to be made, such as those suggested in the lower diagram. The staff are out of their corner; one is holding an activation session of simple exercises; one is helping the ward executive committee plan a social; one is conducting a grooming class; one is doing chores with her regular crew; a wholly spontaneous friendship group is fostered by the staff and is playing cards. The doors of this actual ward were unlocked in 1954.

A rather differing example, Figure 2 diagrams a day hospital where 25 people of both sexes, in early or remitting psychoses, severe neuroses, and character disorders, live together for four weeks to six months. It is hard to think of this as a hospital ward since even staff uniforms have been discarded. The diagram suggests the decentralized, somewhat multi-dimensional network of relationships which exists in this day hospital.

Though it includes a variety of individual somatherapies and psychotherapies, life here centers about large and small group activities, planned and unplanned, with much of what Redl<sup>4</sup> has called marginal interviewing. Considerable withdrawal, regression, and acting out can be permitted in this setting, while the patients keep steady touch with the real world in their nights and weekends at home. Patient A is a young man in an acute schizophrenic illness who chooses isolation during the early weeks of his treatment, tending to spend much time in a reading area where staff are not permitted. His one regular contact, in his psychotherapy hours, appears to be a rather one-sided communication with his doctor. The head nurse and the occupational therapist who have been assigned to his case have established no clear relationship, but accept his need for highly guarded responsiveness. The two women, patients B and C, who have transferred a hostile rivalrous relationship onto each other, are being helped by their occupational therapist, as well as in individual and group psychotherapy, to deal with this.

Let us in Figure 3 focus down on patient B, and on nine of the possible relationships available to her. Like all the other patients, she has assigned to her a doctor, nurse, and occupational therapist; her relation to the caseworker who sees her husband regularly is one largely of fantasy, though she has met this

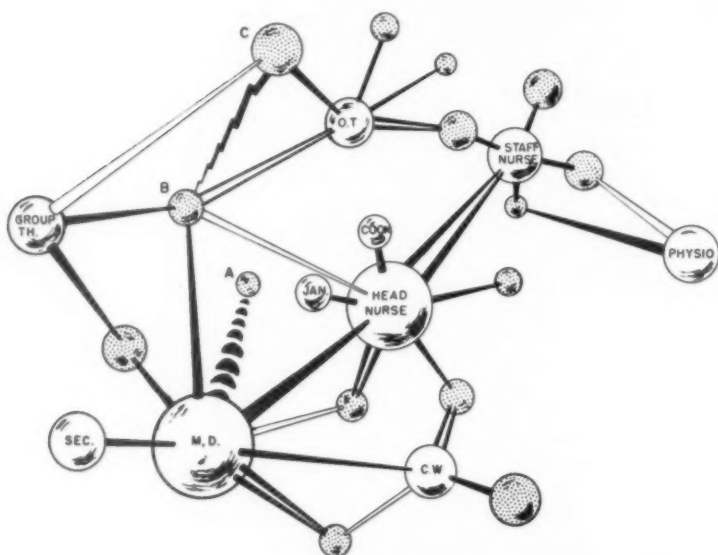


Fig. 2. The nexus of relationships in a day hospital of 25 men and women patients. "A" is a withdrawn, acutely ill, young man. "B" and "C" are two women involved in an actively hostile interrelation.

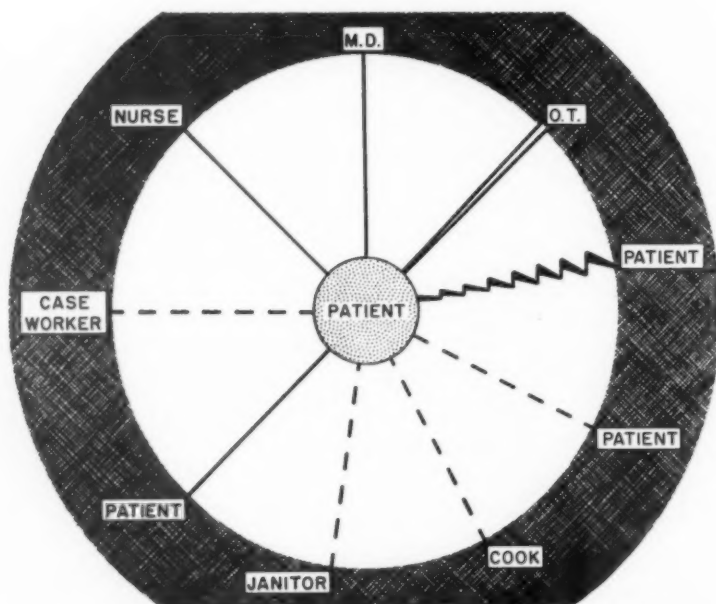


Fig. 3. Our expanded view of patient "B" of figure 2, showing the variety and valence of some of her possible relationships.

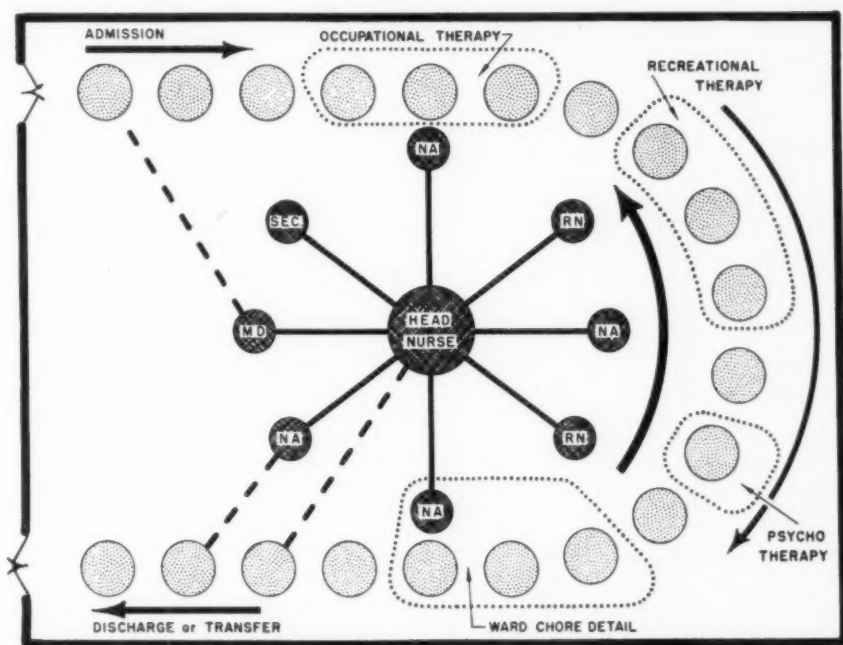


Fig. 4. A high-turnover admitting ward of 20 men patients. Only tentative groupings occur spontaneously, since both staff and patients rotate steadily. How can more interlocking of people on this ward be arranged?

worker; to three other patients she has, respectively, a stably positive, a tentatively positive, and an overtly hostile relationship; her contacts also include a janitor and a cook. Only some of these patients are receiving intensive psychotherapy; some others are receiving intensive casework; a feature of this community is that often a specific therapist or therapy is not prescribed for a patient until he has felt out and made a choice from among the relationships available from staff. His principal therapist may be, as with patient B, a member of disciplines other than psychiatry. Figure 3 indicates a particularly good relationship because of which the occupational therapist was assigned the major therapeutic job, not only through formal occupational therapy media but by regular one-to-one interaction in walks, games, and marginal interviews. The doctor has remained somewhat in the background, contacting the patient twice weekly on ward walks, and supervising (both individually and in team conferences) the occupational therapist's work with her. There is little doubt that the structure and interaction in this setting offer both staff and patients a high degree of self-definition and self-determination, and invite, rather than coerce, the patient to make changes in his adjustment pattern.

The third example illustrates another pattern. Figure 4 conceptualizes a high-turnover closed admitting ward for 20 male patients with diagnoses of psychosis and severe character disorder. In this diagram we see a well-knit staff group including an administrative resident, secretary, registered nurses, and nursing assistants (aides), centralized and operating about the person of the head

nurse. This staff group have a dynamic and benign interest in their patients, and carry out complicated assignments in attitude therapy. However, not only does the stream of patients move constantly and rapidly, but the staff's duties rotate regularly. The problem here is whether such a shifting system can be a meaningful group at all, or merely some sort of friendly aggregate. Several tentative groupings do occur, such as in occupational and recreational therapies, between patients and their psychotherapists, or in ward chore details. But these are mostly outside the ward itself. Accordingly, three methods are being used here to integrate the staff and patient systems better. Twice weekly ward meetings are attended by both patients and staff, chaired by a patient, and partially guided by staff along principles borrowed from social groupwork and group psychotherapy. The nursing staff has initiated the system of assigning particular nurses or aides to relate to the continuing or more difficult patients. And frequently, a younger functional psychotic is asked to act as buddy to an older, brain damaged man, guiding him about the ward, to toilet and dining room. Thus it is intended that the rotations of the staff and the patients (as suggested by arrows) may be somewhat interlocked, rather than occurring in random or even opposite directions.

To summarize, then, we have looked at the interpersonal patterns of three wards. The first, a long-term closed ward, should have had a good chance of becoming a therapeutic community because of its stability in time and place. However, because of its huge size and institutional traditions it actually was a depersonalizing custodial milieu. The second, a short to medium-term day hospital, has by hard and imaginative planning and good relationships between staff become a decentralized therapeutic community. The third, a short-term acute closed ward, poses almost impassable obstacles to community, because of turnover of both patients and staff. However, the fostering of democratic ward meetings, and the assignment of nurses or aides or even patients to individual patients, are partially effective efforts to make an integrated community of this state of flux.

Let us now examine conceptually what the crux is of a therapeutic milieu or community. Is it modern, bright, attractive premises? Or the judicious use, or the abolition, of locks and bars? Is it a high staff-patient ratio, enough trained personnel including psychotherapists and ancillary therapists? Is it the abolition or correction of herding, patronizing, degrading, even sadistic, character-bleaching and soul-destroying programs and attitudes among staff? These important questions, correct in themselves, would appear to assume that the physical and interpersonal environment is some disembodied and abstract entity. In reality, the "environment" is the staff, and the staff are people: people who have defined roles and professional skills; and are themselves exposed to all that is satisfying and questing and frustrating in their patients, who are likewise living people. These questions also do not ask enough about the nature of group life. The staff are the leaders of the community in which they work, and they can never avoid being participants in it. They offer themselves as models of stable humanity, of support and of tolerance; they love and they shepherd and feed; they also guide and they restrict and punish (this term is used shorn of all connotation of narcissistic spite or personal retaliation). They also act out their own sensitivities and biases and weaknesses with their patients, and their patients love them for this provided the staff are honest about it. Staff then cannot simply be anonymous functionaries. They must be sensitive to the overtures of patient to

patient and patient to staff, must discern and promote friendships and natural leaderships, and humbly recognize that the patient often seeks, and finds, his help in the most unlikely people. There are differences in the personality resources of staff members. However normal and stable staff are, they need good supervision and constant team conferencing, so that the solutions to their conflicts can be of non-neurotic proportions, and not acted out to the patient's detriment. The relief of tension, and the constant giving of permission not to be in a hurry, must be as important a part of staff meetings as problem solving.

Who are the staff most influential in a therapeutic community? Probably those working in closest proximity to the patient for the longest hours. This means that nurses, social therapists, and aides stand at the head of the list. A competent or incompetent nursing staff can make or break any hospital ward. Then come occupational and recreational therapists, social groupworkers, and physiotherapists; and we cannot forget the influence of others, such as librarians, administrators and caseworkers, and particularly of the non-professional echelons such as stenographers, cooks, janitors, truck drivers, shop and farm supervisors, and volunteers.

Where does the physician come in this hierarchy of importance? The author believes that he plays a very important, but essentially remote role. The man-hours that he spends living and intermingling with his patients are few, and he is, rather, a participant leader within the staff sub-group. This, of course, omits the important question of his contribution to, and relationship with, the relatively few patients with whom he may carry on regular formal psychotherapy.

What of the many physical and pharmacological therapies which form a significant part of in-patient management? The author agrees with Rashkis' apparent assertion<sup>9</sup> that the more efficiently we learn to carry out milieu therapy, the more we shall find ourselves dispensing with these impersonal methods. The arrival of the ataraxic drugs has obscured an important fact, namely, that we had already just begun to get "over the hump" in our nursing and milieu management of seriously ill persons. In a number of areas, physical restraints had been relegated to the museum; whole chronic wards had been opened; plans for the centralized and treatment of chronically disturbed patients had been shelved; the discharge rate was catching up with the admission rate. And all this just prior to the widespread use of tranquilizers! This does not mean, of course, that we should derogate tranquilizers or somatotherapies, even though recent findings from research on placebo effects reminds us that all therapies fill many personal needs of both patient and staff<sup>2,11</sup>. These media should be prescribed with a design including their social and psychological as well as their neurophysiological effects.

What of the patient, his role and his contribution to the treatment community? This paper has been devoted essentially to a staff perspective, and so an extensive review of the whole concept of patient participation will not be attempted. It is evident, however, that we are in the midst of a revolution in this regard. Let us assume that a planful use of the hospital milieu will result in more, and more successful, remissions or cures. What milieu? What plan? That in which we encourage our patients to play a traditionally passive, tractable, regressed, recipient role, and our staff to interact with them only upon formal lines? Or that in which we stem the tide of flight, resignation, and regression, by encouraging our patients to assume an active and responsible

membership in the treatment community, helping to make their own rules and judgments, interacting vigorously with the staff, and constantly working toward identifying and dealing with difficulties in the total social field? The choice between these values would seem to have a particular pertinence today. This is in the growing tendency to develop psychiatric units in general hospitals, to pull the centre of gravity of psychiatric practice, so to speak, away from the rural island of the mental hospital and into the busy urban university center. Here, in the general hospital, traditional views of staff, of patients, and of their relationship, are particularly firmly entrenched. Accordingly, while methods of individual treatment are progressively improved, planning and purposeful use of the ward milieu may be defaulted, unless patient and persistent and sensitive education of staff can be carried out, their views changed, and their understandably intense anxieties about change allayed.

### Summary

In this paper an attempt is made to examine, by a brief review of literature and of diagrams of actual psychiatric wards, some present thinking about the nature of a treatment environment.

Three "dimensions" are abstracted from published material, two of them American and one English in origin. These are: 1. The idea that a "therapeutic" milieu can be distinguished from an "institutional" one, by its emphasis on making of the staff and patients real people (a personalistic dimension) 2. The idea that the hospital is a society or community, with staff and patients playing integrated parts (an organismic dimension) 3. The idea that traditional staff and patient roles are not helpful in psychiatric treatment, and that more active sharing of responsibility, and more active communication and interaction, between staff and patients, will more effectively combat the regression of psychiatric illness (a communal dimension).

Three examples of wards are given: 1. A large chronic ward, where anti-therapeutic size and tradition pose serious obstacles to community 2. A small day hospital, where a degree of community has been achieved 3. A high turnover admitting ward where experiments are needed to draw the group together.

It would seem that the crucial element in any ward milieu is a good staff, plus an adequate recognition of the humanity of staff. An attempt is made to assess the relative importance of various staff echelons in the daily living of the ward, nurses evidently having the greatest influence and doctors probably very little, at least directly.

Attention is drawn briefly to a probable heightening of conflict regarding change in staff and patient roles, as psychiatry moves more and more into the general hospital, where traditional ideas about staff and patients are clearly established.

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### Résumé

Dans le présent travail, on cherche à examiner, par une brève revue de la littérature et à l'aide de diagrammes de salles de psychiatrie réelles, certaines des idées qui ont cours au sujet de la nature d'un milieu de traitement.

Trois "dimensions" ont été extraites des travaux publiés, deux d'origine américaine et un d'origine anglaise. Ce sont: 1. L'idée qu'un milieu "thérapeutique" peut se distinguer d'un milieu "institutionnel" par l'accent qu'il met sur la considération du personnel et des malades comme des personnes réelles (dimension personnelle); 2. L'idée que l'hôpital est une société ou une collectivité avec un personnel et des malades qui jouent des rôles intégrés (dimension organique); 3. L'idée que les rôles traditionnels du personnel et des malades ne sont pas utiles dans le traitement psychiatrique et qu'un partage plus actif des responsabilités ainsi que des communications et une interaction plus actives entre le personnel et les malades s'opposeront plus effectivement à la régression des maladies psychiatriques (dimension communale).

On donne trois exemples de salles: 1. Une grande salle de malades chroniques où les dimensions antithérapeutiques et la tradition opposent de sérieux obstacles à la collectivité. 2. Un petit hôpital de jour où un certain degré de vie communautaire a été réalisé. 3. Une salle d'admission où il y a un fort mouvement de malades et où il faut tenter des expériences pour resserrer le groupe.

Il semblerait que l'élément crucial dans tout milieu de salle psychiatrique soit un bon personnel et une reconnaissance adéquate de l'humanité du personnel. On cherche à évaluer l'importance relative des divers échelons de personnel dans la vie quotidienne des salles, les infirmières possédant évidemment la plus grande influence et les médecins n'en ayant que très peu, du moins directement.

On mentionne brièvement l'aggravation probable des conflits qu'amène un changement de rôles entre le personnel et les malades, à mesure que la psychiatrie s'achemine de plus en plus vers l'hôpital général, où les idées traditionnelles au sujet du personnel et des malades sont clairement établies.



## A NEW METHOD OF TEACHING PSYCHIATRY TO MEDICAL STUDENTS

C. LAURIN, M.D. AND R. R. LEMIEUX, M.D.<sup>1</sup>

Since psychiatry is no longer considered a secondary subject in the medical curriculum of a faculty of medicine, we have come to realize that our goal is not attained when we have given more theoretical or clinical teaching. The students may gain, through the additional lectures, a better knowledge of symptomatology, psychopathology and current methods of treatment, but there remains for them the difficult problem of integrating such knowledge with the rest of medical science. They do not learn more of an interpersonal relationship, namely the doctor-patient relationship, in which they could recognize the syndromes, realize the validity of the dynamic interpretation and apply the principles of psychotherapy that they were taught.

The change to a greater number of theoretical lectures in psychiatry was met with the desire, on the part of many lecturers, to enlarge the teaching of dynamic psychiatry. It appeared to the authors of this article that the greater need was rather for a personal initiation to psychological treatment, which would later remain applicable in general practice. A new experiment was consequently begun with that very object in mind in September 1955.

### Setting

An outdoor medical clinic for the poor has been conducted for the last ten years by a medical students' club (Conférence Laënnec). This clinic is attached to a charitable organization directed by the Little Sisters of the Assumption. Their medical activities are supervised by senior interns and directed by a professor of medicine, Dr. Roger Dufresne, the Assistant Dean of the Faculty of Medicine of the University of Montreal. Some time in the spring of 1955, a student working at the clinic reported to one of the writers that a patient he had examined presented a major psychiatric disability. It was decided that the student himself would undertake, under supervision, to apply the indicated psychotherapy. Around this first experience, a number of students, interested in this form of psychiatric teaching, were brought together in an organized group in September 1955 and patients who presented emotional problems were referred to the psychiatric clinic by the already existing medical clinic and by the social service of the charitable organization.

This setting offered a very important advantage: because of the cooperation of the social workers, the family and social environments of the patients were never lost sight of by the students. This proved very important in view of the fact that when a patient is hospitalized, his treating doctor tends to forget the patient's milieu from which he is in fact momentarily separated. At no time are psychiatry and psychotherapeutic efforts to be separated from the everyday problems of the patient who has to live and earn his living in a given milieu.

### Favourable Factors

In the opinion of the authors of this article, this form of teaching was highly desirable, and one that they had advocated earlier.<sup>1</sup>

The students who did psychiatric work at the clinic were only nine in number. They were not induced in any way to join the group. They were already attending the medical clinic and were not thinking, or at least the majority of them were not thinking, of taking up psychiatry as a career. Their psychiatric

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work required three hours of their time every week over the entire academic year. The time involved was considerable, yet no university credit was granted.

The authors of this article had noted on different occasions, both at formal lectures and at psychiatric clinics, that the more brilliant students showed a certain reluctance to "give in" to psychiatry while the majority of the students reacted to it with indifference or with no exceptional interest. It is noteworthy that some of the students who had the reaction in question, and who were always inquisitive and sometimes sarcastic, were the first to become interested in the new experiment. It seemed they needed to investigate a science in which, under the guise of ambivalence, so many apparent contradictions took place.

The present writers were interested, personally, in teaching students who intended to go into general practice or surgery. It is their feeling that psychiatry can contribute more to the education of the physician than a mere working knowledge of syndromes. It can give the student an understanding of the personal inter-relationship, which might be defined for our purpose, as a medical psychology applicable to general practice.

#### **Unfavourable Factors**

There were few, in fact. There was no selection of students: they were accepted as they filed in until a group of nine was formed. This left the door open, of course, to students seeking personal treatment, advice or guidance. However, during a period of two years, only one student, who had an unmanageable counter-transference problem, was advised to leave the group. Other students presented problems which were dealt with successfully by their supervisor or were resolved through the group discussions. One particular student warded off his patient whenever he felt threatened in his own system of defence and the patient gave up the clinic after a while.

There was some hesitation, at first, in operating such a service in a charitable organization belonging to a religious order. There lingered most unfavourable memories of psychiatric work within a confessional milieu. Fortunately, our fears proved unfounded. The Sisters who referred cases to us were excellent social workers. There was an added favourable factor in that the students had the opportunity to learn the value of the cooperation with social service. The latter provided information about the milieu in which the patients were living, and this prevented the therapist from straying into an abstract and unrealistic situation. What was feared most was that intervention upon the milieu by the social service might be detrimental to treatment as it would permit the patient to play social service and therapist against each other. However, all triangular situations were avoided due to a proper attitude on the part of the social workers.

#### **Conditions of Admission into the Group**

Third and fourth year medical students were accepted in the group. Third year students were preferred because they were able, if necessary, to treat their patients for two consecutive years, and also because during their 4th year, they could help direct the work at the clinic and act as liaisons between the 3rd year students, the medical clinic, the social workers and the supervisor.

The students agreed, on entering the group, to see the patients assigned to them once a week for one hour and to do so continuously (barring holidays and illnesses) as long as was necessary.

They had weekly group meetings which lasted two hours and were not part of their regular curriculum. During the first hour one of the students, in turn, summarized the interviews he had had with his patient since his last report, and

the group then made their comments. During the second hour the students asked for advice from the supervisor and discussed points of treatments.

### **First Contact with the Patient**

An incoming patient would first have one or two interviews with a student, who would afterwards arrange for a combined interview with the supervisor. The latter, after seeing the patient, would decide whether he was acceptable in the clinic, whether he had a medical condition to be cleared prior to psychotherapy and whether the student with whom he had already had contact was able to establish a good working relationship with him.

From this one interview, the supervisor could arrive at a rough estimate of the patient's personality, of his main mechanisms of defence in a therapeutic relationship and of the major interpersonal difficulties that might be encountered. He was also able to evaluate the quality of the relationship established between the therapist and the patient. Finally, when the patient's case was later discussed in group supervision, he had a mental image of the patient's identity.

Once this joint interview had taken place, the supervisor did not as a rule see the patient again and normal transference was established. Even at that, the major difficulty of the student was that the patient sometimes played against him the fact that, after all, he was not "just as good as the boss".

In two cases only was it necessary for the supervisor to see the patient again. He wished in the first case to assess the degree of depression of a patient with suicidal tendencies and, in the other, he wished to interrupt a treatment where there was an unmanageable counter-transference problem, though the patient actually benefited from the supportive therapy given.

### **Problems Specific to this Form of Learning and Treatment**

This title indicates that the two forms of experience that, in fact, are acquired concomitantly, will not be discussed separately.

a) For the student, the situation is one where he is learning; for the supervisor, it is one where his teaching leads him to learn more about the needs of the students.

b) It is a form of treatment for both the patient and the student. For the latter, the word "treatment" is taken in its looser sense. Some self-analysis takes place in the student and his reactions to his patient are considered with a view to correcting his attitudes. It is also obvious that the social workers derived some benefit from the experience, just as the students did from contact with them, but this paper is not meant to deal with that aspect of the experiment.

#### **A. Problems of the students**

The difficulties encountered in the first few months of the therapeutic relationship are always the same for a given group of students who are at the same level of experience (whether they are students of 3rd or 4th year of medicine).

- 1 They at first had a feeling of therapeutic impotence, which they voiced in many ways: "She has nothing else to tell me . . . I had no more questions to ask . . . Where do we go from here? . . . I don't know what the diagnosis should be . . . She does not want to be treated . . . It's useless, I don't know enough about it".
- 2 The students reacted most of the time to their feeling of inadequacy by taking a directive attitude and trying to hasten a change in the neurotic condition of their patients. The directive attitude in question was one of the major difficulties encountered because, at the beginning of a treatment, it could lead the

student to commit a major mistake that might break the relationship altogether. As a matter of fact, one student did break two therapeutic relationships in a row.

- 3 Some students also reacted to their feeling of impotence by becoming methodical and "scientifically objective". They concealed their lack of assurance under a circumstantial investigation of their patients' histories. It had been expected that the students might exhibit voyeuristic tendencies, but it was found that such was not the case. The students were held back by their own timidity resulting from their own backgrounds. Their control over any voyeuristic tendencies might have another explanation. The writers feel that voyeurism is usually accompanied by a wish to see right away, without effort or involvement on the part of the voyeur who is satisfying a neurotic need. Those circumstances were not met at the clinic because the students were expected to take part in a therapeutic situation for lengthy periods of time. Voyeuristic tendencies were more common, in the writers' leading experience in mental hospitals, where students attended for only a few hours every week. One could theorize that the psychiatric teaching given at the clinic had the advantage of involving the therapist in an entire relationship in the extent that he could no longer satisfy a neurotic need that would require a lack of personal involvement to be present.
- 4 The students' directive attitude manifested itself also in a tendency to resort with the patient to leading questions, inspired by non-assimilated theoretical notions. It was difficult at first for the supervisor to verify that leading questions had been used, since the students were quite aware of what they had done and "forgot" to mention, during the group discussions, the method of questioning they had employed. On the other hand, the supervisor hesitated to urge the students to explain more fully what methods they had used in the presence of the group, as the students might then have ceased to be frank in their discussions. However, when the students realized that they all had similar difficulties with their patients, it became easier for the supervisor to go into instances of leading questions and the students volunteered information in that regard more freely.
- 5 Another stumbling block of the students at the beginning of their therapeutic effort was their inability to cope with a patient's silence, which is well known to be more pregnant with useful information than an incessant rambling that distracts attention from the true object of an interview. This difficulty was a major concern to the writers, who feel that most of the important errors a general practitioner can make in his office are related to his inability to remain silent and non-directive when he wishes to obtain more information as to a patient's motivation in seeking a consultation. If the entire experience of the psychiatric clinic had met with some success only in this particular element of psychiatric treatment, the writers feel that the experiment would have been worthwhile. After a time, the students became aware of the various motives their patients could have during the treatment procedure and consequently realized what benefits there are in allowing anxiety to swell up in a patient for a discharge through speech.
- 6 One can easily imagine the enthusiasm a student may have when he encounters a situation that illustrates in his mind the theoretical information he has received at lectures. This enthusiasm leads some students to hasty interpretations of insufficient material and this sometimes provokes undue resistance in the

patients. However, the writers found that the very fact that many students made such hasty interpretations within a short span of time, that is, each at the beginning of his relationship with a patient, caused the students to realize better their mistakes and to understand better the supervisor's cautionings.

- 7 Last but not least, there were encountered counter-transference problems which protected the patients by doing away with the objectivity of their therapists. Counter-transference at the beginning usually took the form of a compromise between patient and therapist. They made a tacit "Gentleman's Agreement" whereby they remained in territories that were less anxiety-provoking for both of them and which gave them some temporary benefit.

The writers feel that the study of these problems within a group was useful; in fact, more useful than individual supervision might have been. They had previously been led to realize that anxieties connected with therapeutic activity were more easily relieved in group than in individual supervision. There is an inclination in individual supervision to interpret reassurance from the supervisor as a gentle but not realistic encouragement, while seeing how others have made the same mistakes becomes more reassuring because of the reduction to a common denominator.

It soon became apparent to the members of the group that the "urgent" questions submitted to the supervisor, who was expected to provide a directive attitude that would immediately produce results, resembled closely the very situations that were met by the therapists with their patients. The therapists were exhibiting in their demands on the supervisor the same urgency they had seen in their patients in regard to themselves. In such circumstances, anxiety in the therapist could be relieved when he laughed at his own predicament.

Each of the students was somewhat in the position of the "clerc-docteur" of former times (apprenticeship method of medical training). He went to the teacher's home, could feel the latter's calm in facing a situation, his lack of hastiness in searching for a solution and was told to listen to the patient carefully and for longer periods at a time just as he himself, the student, was listened to by the teacher. He was thus able to identify himself with both his patient and his teacher and correct his therapeutic attitude and technique.

There were times when the supervisor refused to advise the therapist in his difficulties because he felt the therapist simply had to learn to solve problems with the tool he had at hand, namely his own personality, which he had to get to know. This non-committal attitude could not but generate the same attitude in the student, namely, that he had to refrain from imposing his will on the patient. In this way, he learned that it was his own personality that was therapeutic. His personality had a corrective action on the patient by way of comparison with former important figures in the life of the patient. Of course, acquiring this skill through personal involvement called for self-analysis on the part of the student and he was guided by the supervisor who gave him constant support. This was the same kind of support that the therapist needed to give to the patient so as to encourage him to continue his own study of himself, facing a therapist who accepted him just as the supervisor accepted the therapist.

#### *B. Problems of the patients*

The type of therapeutic relationship offered created difficulties also for the patient, who was aware that his therapist was young, inexperienced and supervised by a higher authority. He had a tendency, chiefly at the beginning of the treatment, to minimize and manipulate his therapist. This added a new strength to his resistance.

On the other hand, the situation was in a way less anxiety-provoking and favoured the establishment of a "friendly relationship". The student was pleased to get a well-circumstantiated psychiatric history and information on the personal background of the patient, in order to hide meanwhile his personal feeling of uneasiness on delving into the intimacy of the patient. As for the patient, he was happy to have an attentive listener, perhaps for the first time in his life.

At the beginning, this can be, for the patient, a quite "charming relationship" in which he has the impression he is in control of the situation. While this is not therapeutic, the writers think it has an advantage in that it facilitates the "prise de contact" for the patient; yet it would leave him to his insecurity, if it lasted unduly. However, due to the group supervision, the therapist gradually learns to trust his own abilities and the patient develops, in his presence, a working anxiety at the same time as he gains confidence in his therapist's ability to handle the situation. As mentioned previously, patients generally come to the clinic from a milieu of low-level income. Most often their neurotic problems are intertwined with very realistic and hard-to-face objective conditions of poverty, unemployment, large families, sordid dwellings, etc. If thorough ventilation is allowed at the beginning of the treatment, the patient is drawn, little by little, to consider the share of personal psychological problems he adds to the overall conflict. He gets to realize better his personal responsibilities, whereas at first he was only too inclined to project them onto his poor living conditions. It is only afterwards that the treatment will allow for a consideration of the inter-relationship difficulties of the patient. It is only through a revival of the patient's difficulties in relation to the therapist that his deeper conflicts may be investigated, the very conflicts that render his adaptation to his milieu impossible.

### C. *The teacher*

This experience has been extremely rewarding for the teachers. Supervision constitutes for the authors another means of deepening their understanding of the difficulties they once had themselves. As teachers, they get closer to the psychology of the medical student and are then in a better position to modify eventually their theoretical teaching so as to give the undergraduate a more practical knowledge of psychiatry.

## Results

Results should be considered from the two points of view of treatment and of teaching.

### A. *Treatment*

Results are, as usual, difficult to assess but, compared with general experience, they are in no way disappointing. They are sufficient to establish that this form of teaching has not been detrimental to the patient.

Nine students, three of whom kept their cases two years, had a total of thirteen cases:

|                         |                     |
|-------------------------|---------------------|
| Alcoholism: 3           | Anxiety neurosis: 1 |
| Reactive depressions: 4 | Schizophrenia: 2    |
| Hypochondriasis: 2      | Phobia: 1           |

1 No success was met with alcoholics: they all left.

2 A case of reactive depression considerably improved.

Another improved.

Third depressive: though not improved basically, succeeded in staying out of hospital, making a marginal adaptation for a long while, then improved to

such an extent that she became independent enough to go and live with her husband, without any support from her parents with whom she had been living for a long time.

Fourth depressive: received only supportive therapy for one year and was able to terminate a commercial course. After a period of reverting to dependence, she is now working steadily and becoming independent.

- 3 One patient with hypochondriasis improved moderately but went into reactive depression when the therapist did not see her for three weeks at the time of his examinations.

The other was not basically changed but succeeded in securing work to support his family.

- 4 A chronic schizophrenic, though not improved, remained out of hospital and was able to take work. Feeling anxious again, he recently came back to the clinic and will be given further treatment.

The other disappeared.

- 5 Phobic: unchanged after 5 months, is still under treatment.

- 6 Patient with anxiety neurosis: discontinued treatment.

#### B. Teaching

Teaching was extremely rewarding.

Nine students participated: four over a period of two years, three of them carrying their cases over to a second year. None abandoned the group though one rejected two patients in succession. One was invited to leave the group because of severe counter-transference problems.

Two of the students, on terminating their medical studies, went into psychiatry, but their decision to do so had been made before they entered the group. The others are in, or probably will go into, general practice or specialized fields. From the teachers' point of view, this is excellent as the object of their teaching was not to make psychiatrists out of medical students but rather to give future physicians a working knowledge of psychiatry.

A few students showed less interest in the group discussions during their second year. The best explanation that can be given is that they were annoyed at the mistakes of the beginners who had just joined the group. Also this might have been their manner of asserting their independence and their superiority over their junior colleagues. However, their attendance improved after a while and they did not abandon their patients.

Two students, whose interest in their patients was waning, were reluctant to admit it in front of the others and, as a consequence, hardly showed it at group meetings. They were given individual support and interviews. The possibility of separating third and fourth year students is being considered with a view to avoiding repetition and annoyance. Yet we hesitate to do so because the students with one year's experience have some critical ability which can be applied to beginners' difficulties.

One of the students summed up the group's experience in the following manner: "In the opinion of us all, this experience has helped us to sort out the various etiological factors, both physical and psychological, of different forms of disease; when we meet with a combination of such factors, we shall be in a better position to distinguish and correct them. Our experience will enable us to treat benign neurotic conditions and behaviour disorders without being obliged to refer them constantly to psychiatrists"<sup>2</sup>.

The students' supervisors also drew his own conclusions from the experience. The medical student is all too much inclined to rely upon definite diagnoses, which

call for precise medications and treatments. Later on, in general practice, he sometimes becomes "professorial" and protective, behaves as if he knew everything about his "poor wacky patients" and does not see that in acting as he does, he is hiding his own inability to understand and treat their neurotic problems. The benefits to be derived from such an experience can be listed as follows: prolonged involvement in a therapeutic situation, analysis of one's own reactions, a certain doubtingness which is conducive to further efforts to understand i.e. research, reduction of counter-transference difficulties and development of a true sense of objectivity.

During the first stages of the experience, the student is apt to become confused in his conception of psychiatry: the reality of psychotherapy does not conform to what he has learned from theoretical teaching. However, after going through a phase of doubt and anxiety, coupled with a feeling of therapeutic impotence (who ever did grow completely out of that feeling and is it even desirable to do so?) the student comes to realize that the individual, in his constant effort to adapt himself, varies his mental mechanisms of defence and that it would be vain and useless to concern oneself primarily with diagnosis. During his learning process, the young therapist has a true and living contact with the numerous mechanisms of defence and applies himself to the task of helping the patient find a better formula of adaptation.

The Department of Psychiatry of the University of Montreal takes a keen interest in this form of teaching and is thinking of enlarging its scope. It might even become integrated in the formal curriculum of medical students.

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#### Résumé

Les auteurs décrivent une nouvelle méthode d'enseignement de la psychiatrie à des étudiants en médecine de 3<sup>e</sup> et de 4<sup>e</sup> année. Dans cette expérience, on a tenté de faire saisir la dynamique psychologique du malade par une expérience psychothérapeutique dirigée, au cours de laquelle l'étudiant en médecine rapporte au "superviseur", dans des séances de groupe, les entrevues qu'il a eues avec le malade.

L'étudiant reçoit à la fois la critique de ses pairs et celle du "superviseur", tandis que tous les étudiants réunis peuvent réfléchir sur des fautes qui sont communes à tous et à chacun. La structuration de la personnalité morbide du malade est mieux comprise et l'étudiant se place dans un jour où, à travers la critique, il peut se rendre compte de ses propres difficultés dans la relation thérapeutique.

Le moins qu'on puisse dire de cette expérience, c'est que le malade n'en a pas souffert. Certains même se sont améliorés malgré l'inexpérience des élèves-thérapeutes. Les élèves en ont profité même s'ils se destinaient à la médecine générale ou à la chirurgie: le questionnaire à l'examen ou le stage psychiatrique au cours de leur internat nous l'ont démontré.

Nous croyons que ce genre d'expérience, s'il est étendu à un plus grand nombre d'élèves, pourrait fortement favoriser la pratique d'une forme de psychothérapie à la mesure du praticien général.



## THE PART-TIME MENTAL HEALTH CLINIC

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In most countries psychiatric out-patient clinics were first developed in connection with the Mental Hospitals. Today, however, most authors agree that although undoubtedly a great pioneering work has been done by these clinics, it is doubtful whether such a connection should be continued in the future; rather should the psychiatric clinic be connected with the out-patient service of the general hospital, (Ancheren 1953). One of the oldest examples of such a psychiatric clinic in the community is the "Hjälpyra för psykisk sjuka" which, in the beginning of this century, was established on a private basis in Stockholm, Sweden (Wigert 1941).

During the last 10 years the number of full-time or part-time psychiatric out-patient clinics has been steadily rising in the United States and Canada. The minimum need for this type of clinic has been estimated to one full-time clinic for each 50,000 population (Barton 1952). The existing facilities, however, are far from reaching this goal in most states and provinces. Saskatchewan, presently with 5 full-time and 10 part-time clinics for a population of 900,000, (1957) is one of the closest to the goal. In working towards this goal of adequate psychiatric facilities in a community, the policy in Saskatchewan has been first to establish a part-time clinic, staffed from the nearest full-time clinic, and in a matter of a year or more, when it was felt that the idea had been accepted by the physicians and the people of the community, and the work load had increased accordingly, the clinic would begin to operate on a full-time basis, and when also this had been accepted by and incorporated in the community, a psychiatric unit in the local hospital might have been added.

The purpose of the present paper is to illustrate and discuss the role of the temporary, part-time clinic. As it has already been indicated above, the main role is seen as one of establishing a relationship with the community which will facilitate the ultimate establishment of a full-time clinic. In addition more tangible goals are the provision of consultation facilities for the general practitioner and, although to a very limited extent, also psychiatric treatment and follow-up care for the far-away mental hospital. While the value of the part-time clinic in providing consultation hardly can be over-estimated, the role as a therapeutic body is minimal, something which often can prove frustrating to the psychiatrist, who, as any physician, likes to perceive his role as the one of a therapist.

The value of the clinic in preparing the soil for a permanent unit is more abstract and difficult to evaluate. It will depend, to a great extent, on the enthusiasm with which the psychiatrist comes to the clinics and on his preparedness to take on extra case-loads and extra tasks such as lecturing, etc. It will also depend on how valuable the referring bodies will find the reports they receive in return and which therefore must be practical. The general practitioner is not interested in a deep analysis of the dynamics in a patient's conflicts, but rather in practical suggestions as to what he should do with him: Should he send him to the mental hospital for treatment? Should he keep seeing him and reassuring him three times a week, as he has been doing? Or is there maybe a third and better way out? Whatever the suggestion it must be practical, and it must suggest a facility which is available and within the means and scope of the patient in question. This may sound as common sense, but psychiatrists have a reputation for disregarding common sense!

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Many authors have pointed to the great need for more teaching of psychiatry to the medical student, so that he, as a future general practitioner, can carry his load in treating the mentally ill (McKerracher 1958). Until this goal is achieved, however, the community-psychiatrist has a great responsibility for teaching the general practitioner psychiatry and promoting his interest in this type of patient.

The following example may serve as an illustration of how even the part-time clinic can save beds in the mental hospital by keeping patients ambulatory in the community and without losing sight of the primary goal, i.e., the welfare of the individual and of society.

The patient was a middle-aged, single lady, who had spent more than two years in the local mental hospital (100 miles away), under the diagnosis of a schizophrenic disorder. She had then been boarded out to the Sisters of a Catholic nursing home where she had been employed as a dish-washer and kitchen-help. The Sisters now presented her at the Mental Health Clinic with the complaints that the patient occasionally took "noisy" spells, when she would lock herself in the bathroom alone, "and then it sounds like an Indian Pow-Wow in there". Also, in her sleep she would talk rather noisily at times. The Sisters complained further that she seemed to have no memory whatsoever. In spite of long term employment in the kitchen she did not yet seem to know where to place the washed articles, and she was unable to understand and remember orders. The Sisters were in other words quite "fed up" and felt that it would be necessary to have the patient returned to the mental hospital, although they, knowing the patient's feelings in this regard, did feel quite sorry for having to do this to her!

After the patient had been seen—she was indeed quite severely regressed—it was suggested that the Sisters try her for another month on a small dosage of "Largactil" and at the same time they were given some general advice as to how to handle her. Thus they were advised against trying her on other tasks than dishwashing "to give her a chance", but at no time did the psychiatrist make the Sisters feel that he would be unwilling to help them return the patient to hospital if this was necessary.

The Sisters returned for their appointment at the next regular clinic a month later, very pleased with the improvement the patient had shown! There had been no more "Indian Pow Wows" and she had been friendly and cooperative in every respect, although her general usefulness had not increased.

It was suggested that Sisters continue her on "Largactil" and they were reassured that if at any time they had further problems, they could phone and make an appointment for the next clinic. This, however, has not proven necessary.

To summarize, it will be understood that the part-time clinic, in its pioneering capacity, must be prepared to meet with resistance from the physicians in terms of reluctance to refer patients, and from the community in terms of reluctance to attend, rationalizing that there is a stigma involved. This resistance, however, can be modified, if everybody can be made to feel they gain, the physician in terms of reports they can use and the patients in terms of significant advice and improvement. In breaking down the resistance, the psychiatrist should attempt to utilize his enthusiasm and make use of newspapers, radio, T.V. and public lecturing as indicated.

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### Résumé

La clinique à temps partiel, dans cette période de début, rencontre de la résistance de la part des médecins qui hésitent à référer leurs malades et de la part de la population qui craint de s'y rendre à cause du stigma qui y est attaché. Cette résistance cependant tombe lorsque chacun y trouve son profit. Les médecins reçoivent un rapport qu'ils peuvent par la suite utiliser et les patients apprécient les avis éclairés et les améliorations appréciables. L'enthousiasme du psychiatre et l'utilisation de la presse, de la radio et des conférences publiques viennent habituellement à bout de cette résistance.



### Announcement

Members of C.P.A. will be interested to learn of the appointment of **Dr. Morgan Martin** as Chief of the Mental Health Division in the Department of National Health and Welfare.

A graduate of the medical school at Queen's University, Dr. Martin went direct to the Royal Canadian Army Medical Corps, in which he served from 1943 to 1946. Going West in 1947 he held several appointments in Saskatchewan mental hospitals. In 1951 he became Director of a mental health clinic in Regina, this in turn leading to directorship of the Regina General Hospital's psychiatric ward. He was the first president of the Psychiatric Association in that Province of Saskatchewan.

In the Saskatchewan capital he was visiting consultant in psychiatry to a wide variety of centres. He also taught student and graduate nurses, public health nurses, medical students, general practitioners, clergy and community groups. His interest in group work led to positions on the staffs of group development institutes, including the National Training Laboratory in Bethel, Maine. He was the first president of the Psychiatric Association in that province.

Last year he studied administration and community psychiatry at Columbia University.

During the past summer Dr. Martin has been attached to a large United States mental hospital, developing a program designed to reduce the length of stay in the psychiatric wards.

He is married to the former Mary Folger of Kingston and they have three daughters.



## LES ANGOISSES ET LES DEFENSES CHEZ L'ENFANT DEPRIME\*

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Nous avons choisi pour sujet les dépressions de l'enfance, parce que ces états sont moins bien compris et, assez souvent, méconnus en psychiatrie infantile. Nous pourrions étayer cette opinion en signalant, par exemple, que dans le manuel de psychiatrie infantile de langue anglaise le plus répandu, il n'apparaît aucune entrée à la table des matières sous le titre «dépression». Par comparaison, il en existe douze sous le titre «schizophrénie». On y trouve des chapitres entiers consacrés à la colère, la jalousie, la peur; aucun traitant de la tristesse, du chagrin, de la mélancolie ou du deuil. Il n'y a qu'une mention de la solitude (*esseulement*) ou de l'ennui. L'absence de ce chapitre sur la dépression n'est pas le résultat d'une omission, mais reflète plutôt l'attitude qui voudrait que ce terme fût réservé aux réactions des adultes.

La psychiatrie infantile d'Amérique du Nord a très peu contribué au sujet des dépressions. Spitz utilisait au début le terme «hospitalisme» pour qualifier ce qu'il appela plus tard «dépression anaclitique». Engel et Reichsman, plus récemment, ont porté à notre attention le cas intrigant et fort discuté de Monica, décrivant son état comme s'il s'agissait d'une dépression. Le travail de Benedek, *Vers une biologie de la constellation dépressive*, s'avère très stimulant aux psychiatres d'enfants. Enfin, depuis 1935, la dépression infantile a été étudiée plus en détail par les psychiatres d'Angleterre.

Mes premières constatations des états dépressifs de l'enfant découlent de l'intérêt que je portai à la nostalgie,<sup>2</sup> dans la clinique du docteur Kanner, en 1947. Depuis lors, mon intérêt dans le sujet a persisté et j'ai retracé et étudié quelque 75 rapports de cas dans une quinzaine de camps aux Etats-Unis et au Canada. En outre, il m'a été donné d'observer plusieurs autres cas dans nos propres camps et dans les salles du Montreal Children's Hospital.

La nostalgie peut se manifester de bien des façons. Elle est en général—pas toujours—engendrée par l'éloignement de la maison. Elle peut être également un moyen d'échapper à certain conflits nés de la nécessité de s'associer à des étrangers, ou bien d'attirer l'attention sur soi si l'on se sent seul, ou simplement de forcer l'entourage à montrer du souci et de la sympathie. Dans sa forme la plus pure, elle est rattachée aux luttes de la croissance. Elle peut être définie comme étant un ensemble de symptômes, habituellement associés à une séparation de la maison, qui reflètent un état latent de dépression auquel l'enfant cherche à s'ajuster.

McCann prétend que la nostalgie est le fait de toutes les contrées et de tous les âges. Elle s'enracine dans l'échelle des êtres plus profondément qu'au niveau humain, puisqu'elle atteint même les bêtes fauves et les animaux apprivoisés. Dans le psaume 137:1 on peut lire:

*Sur les rives de Babylone*

*Nous nous sommes assis, ah, nous avons pleuré,*

*En nous remémorant Sion.*

Hippocrate remarquait que lorsque les peuplades des plaines ou des montagnes étaient transplantées en d'autres terrains, un dérangement grave s'emparait d'elles; et que l'homme semble assujéti à des influences topographiques dès sa naissance.

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<sup>2</sup>Homesickness.

On trouve des travaux sur ce sujet remontant à 1685, et de nombreux autres depuis. Bien des articles récents ont traité des bouleversements chez les millions d'êtres humains qui furent arrachés, contre leur gré, à leur pays d'origine.

### Signes et symptômes

Les symptômes les plus communs, tels qu'on pouvait les observer dans les trois quarts des cas, étaient: des «crises de larmes», l'«esroulement», le «découragement». Puis venaient, dans la moitié environ des cas, le «désir de rentrer chez soi», le «manque d'appétit» et l'«inaction». Il est quelque peu surprenant que le «désir de rentrer chez soi» ne soit pas plus fréquent. Cependant, nous connaissons tous le cas de l'enfant qui essaie courageusement de surmonter son ennui de la maison. Le «peu d'appétit» et l'«inaction» sont souvent les premiers symptômes d'une maladie physique; il faut donc être prudent avant de les considérer comme étant dus à la nostalgie. Ce sont aussi des symptômes caractéristiques de la dépression chez l'adulte.

Il existe un autre groupe important de symptômes, qui peut décrire ou suggérer la maladie physique, ou au contraire, n'être que la répercussion, au physique, d'un état de tension émotionnelle et d'anxiété. On les rencontrait dans à peu près un cinquième de nos cas. Ce sont, par ordre de fréquence, des troubles du sommeil, des douleurs abdominales, des maux de tête; de la constipation ou de la diarrhée, et des vomissements. Il va sans dire que de tels enfants devraient être examinés par un praticien.

Un autre groupe de symptômes, apparaissant à peu près aussi souvent que le précédent, c'est-à-dire dans un cinquième à un quart des cas, s'avère peut-être le plus difficile à traiter. Ce sont les «sentiments de persécution», la conviction que «tout le monde est contre moi», et que «rien ne va comme il faut».

En fin, d'autres symptômes peuvent être rencontrés, et parmi ceux-ci: une dépendance excessive, une activité fébrile (dans à peu près un cinquième des cas); ou, moins souvent, de l'agressivité, du négativisme et une constante recherche de l'attention.

### Epidémiologie

Considérons maintenant la fréquence de ces états. Un observateur a déclaré que tout enfant doit faire face à ce problème, mais que nous voyons seulement ceux qui ont été incapables d'y apporter une solution satisfaisante. Nous voyons certains aspects de ce complexe de symptômes, mais il ne s'agit pas là de ce qu'on appelle nostalgie. Il s'agit d'un état d'âme ou d'une réaction (s'exprimant par la déception ou la tristesse) à quelque cause extérieure connue. Il en résulterait chez l'enfant un état réactionnel dû à la réactivation par le problème actuel d'un conflit passé.

Il est certain que le degré de nostalgie varie avec le degré de sécurité présente dans nos foyers et nos groupements communautaires. Certains enfants seront capables de quitter leur foyer avec l'impression qu'ils y reviendront, et qu'à leur retour, ils le retrouveront, avec ses habitants, heureux et identique. Certes, plus nous nous rendons compte de l'existence et de la signification de ces symptômes, plus nous aurons l'occasion de reconnaître le conflit en cause ou du moins de le deviner.

### Un concept théorique

Ces symptômes de dépression et de nostalgie se manifestent au moment où la structure dynamique du système psycho-physique ne peut plus faire face à l'entourage. L'atmosphère familiale avec ses particularités peut fréquemment

dissimuler les structures pathologiques du système psycho-physique, et lorsque l'individu change de milieu, des symptômes pathologiques peuvent devenir plus évidents.

Ces symptômes peuvent être groupés en cinq catégories:

1. psychosomatiques
2. soupçon et paranoïa
3. sentiment de privation
4. réaction d'évitement
5. négation maniaque.

Si nous nous demandons à quel moment du développement émotionnel d'un enfant ces symptômes apparaissent pour la première fois, nous butons sur le problème complexe et fort débattu du développement de la personnalité du nourrisson et du bébé. A ce point de la discussion, je voudrais appuyer mon exposé sur les idées formulées par mon plus récent maître, le docteur Clifford Scott, et sur celles du pédiatre et psychanalyste, le docteur D. W. Winnicott.

Leurs aperçus développent les idées de Freud, Abraham, Rado, Helene Deutsch, Melanie Klein. J'y ajouterai un résumé de ma propre interprétation du développement infantile conduisant à la dépression. La forme que prend la dépression découlera de l'histoire de la maladie au fur et à mesure que l'individu se développe et mûrit.

La première relation interpersonnelle vécue par l'être humain est celle que Winnicott décrit ainsi: «la mère tenant son enfant dans une situation». La capacité de la mère à «tenir une situation» pour son bébé déterminera la sorte d'objets internes qui se développera chez le nourrisson. Dans cette situation maternelle, il ressent des impressions au sujet de: l'accrochage, l'espace, le temps, le contact, l'aspiration d'air, la succion et l'absorption de lait, l'émission d'urine et de selles, le mouvement du corps et des membres, le sommeil, tout cela au cours de la période de son premier développement. Si ces impressions ont été perçues comme gratifiantes par l'enfant, il en retire du plaisir et construit peu à peu une sorte d'association plaisante à l'intérieur vis-à-vis de ces activités. Au contraire, si elles sont frustrantes, il amassera des associations intérieures qu'en adultes, nous qualifions de sentiments de sentiments de colère. Grâce à la mère «tenant son bébé dans une situation», un monde intérieur de souvenirs, d'objets et d'associations se bâtit peu à peu; et ce n'est que fort lentement que l'enfant perçoit l'existence d'un monde extérieur qu'il peut comparer avec son monde intérieur. En se développant, il devient capable de «déformer» le monde intérieur sur l'extérieur pour sauvegarder son *moi* émotionnel. Cette «déformation» est accomplie par des mécanismes de projection, d'incorporation ou d'internalisation. A ce stade primitif, les activités agréables ou coléreuses peuvent être dirigées au dehors ou au dedans, et ceci pourrait expliquer la quantité et la variété des maladies rencontrées chez le nourrisson. Les échanges entre ces deux mondes s'accomplissent à ce stade par le moyen de l'inspiration et de l'expiration, la déglutition, la régurgitation, la rétention d'urine ou de matières fécales, ou leur rejet fréquent par diarrhée ou polyurie. Voilà sans doute pourquoi l'on rencontre la déshydratation, à ce jeune âge, plus fréquemment qu'à aucun autre moment de l'histoire naturelle de l'être humain. Les maladies émotionnelles les plus graves ont leur source à cette époque s'il n'y a pas de «mère tenant l'enfant» et si la «situation» est frustrante. Goldfarb, Spitz et Bowlby ont fort bien compris et démontré cette partie du développement infantile.

Au tout début, les mondes intérieur et extérieur sont formés de ce qu'on appellera plus tard des objets partiels, c'est-à-dire, mamelons, doigts, seins, mains, lèvres, yeux, visages, etc. Ce n'est que lentement que se forme le concept du soi comme une personne complète distincte d'autres personnes. En même temps qu'augmente la complexité de disposer des objets intérieurs et extérieurs, augmente aussi peu à peu la complexité du développement affectif. A l'âge adulte, les plus simples de ces sentiments s'appelleront «bons», «plaisants», «gratifiants», «satisfaisants», «aimants» d'une part, et d'autre part, «mauvais», «déplaisants», «coléreux», «douloureux», «rageurs», «haineux», «craintifs».

Tôt ou tard, le nourrisson développe suffisamment d'esprit de synthèse, d'intégration ou d'organisation pour s'apercevoir que ses premiers souvenirs de mère partielle, aimante et satisfaisante, et ses souvenirs subséquents de sa mère comme un tout, et aussi les formes de haine opposées, sont des parties de la seule et même mère dans une situation. Parallèlement à cette intégration de l'amour et de la haine peut se développer alors un nouvel état affectif. Comme l'a dit Scott, «la réalisation que le maximum d'amour et le maximum de haine, peuvent être exprimés par les mêmes organes physiques, que l'amour et la haine maximum peuvent être ressentis envers le même objet, et que cet objet peut-être à la fois satisfaisant et frustrant, et peut paraître aimant et détestant», est un moment où apparaissent les premiers modèles de tristesse, souci, esseulement et dépression.

La tolérance à ce nouvel état dépendra de ce que Klein appelle «la provision des bonnes choses à l'intérieur», et celle-ci dépend de la qualité des soins maternels donnés au bébé. Il supportera la tristesse et la dépression, et ne se laissera pas abattre, si sa «provision de bonnes choses» est suffisante et plus grande que sa «provision de mauvaises choses». La culpabilité devient l'angoisse et l'auto-accusation telles que ressenties par l'enfant dépendant alors qu'il subit des poussées haineuses et destructives vis-à-vis d'une mère qu'il aime et à qui il doit son existence. La dépression comprend la culpabilité et la confusion qui naissent d'un tel conflit. La culpabilité accompagne la tristesse et la dépression, parce qu'elle demande le même degré d'intégration. La dépression s'avère moins grave à mesure que la réalisation se fait plus nette que la mère ne deviendra pas non-aimante et non-existante. La rapidité avec laquelle quelqu'un surmonte ses sentiments de dépression est une faculté très importante qui dépend de la rapidité avec laquelle il aura réalisé que les forces aimantes amassées en lui sont plus fortes que les forces destructives. C'est cet état de choses dans un enfant qui peut conduire à un deuil normal réparateur.

Lorsque les provisions de bonnes et de mauvaises choses sont en balance égale ou négative, et qu'ainsi la dépression ne peut être tolérée, certains mécanismes de défense entrent en jeu. Helene Deutsch, en 1933, parlait de paranoïa et de manie comme de défenses contre la dépression, l'une régressive et l'autre progressive. Elle rattachait la paranoïa à une projection de mauvaises choses sur le persécuteur et la manie à la négation de la dépression. Dans son article intitulé *Objets transitionnels et phénomènes transitionnels*, Winnicott propose le concept de l'existence d'un double monde, intérieur et extérieur, et aussi d'une troisième entité quelque part entre ces deux mondes. «Ce serait une région, qui n'est pas contestée parce qu'on n'a rien réclamé en sa faveur, sinon son existence en tant que lieu de repos pour l'individu perpétuellement engagé dans le travail humain de conserver la réalité intérieure et extérieure séparées et cependant interreliées.» Il veut parler des habitudes fréquentes telles que, sucer une couverture ou tortiller ses cheveux, le vieil ours en peluche ou le bout de tissu qui semble reconforter

l'enfant quand il sombre dans le sommeil. Il me semble que cette «situation interpolée» peut servir de substitut ou de «deuil ineffectif» et que ce genre d'habitude peut persister chez l'enfant et l'adulte pendant fort longtemps, ainsi que peuvent persister les défenses psychosomatiques, paranoïaques ou maniaques.

Je me demandais en préparant ce travail, si j'avais en moi assez de «bonnes» connaissances de la dépression infantile à vous offrir et je passai de longs moments à «rassembler anxieusement ma pensée». Je n'écrivais pas, je rapprochais des expériences personnelles d'idées trouvées à l'extérieur, dans la littérature ou la discussion avec d'autres personnes. Rien ne fut noté. Ce fut un temps d'espoir et de désespoir, de souci et de confiance. Certains d'entre nous trouvent difficile de dépasser ce stade de «rumination mentale» ou de «deuil ineffectif». Je me demande si cet état n'aurait pas un rapport avec la «situation interpolée de Winnicott et ne serait pas une défense régressive étroitement rattachée aux «objets et phénomènes transitionnels».

### *Observation*

Essayons maintenant de rassembler ces idées sur la symptomatologie et le concept théorique à l'aide d'une illustration clinique.

Il s'agit d'un enfant qui vint à notre camp au cours de trois étés consécutifs, à 8, 9 et 10 ans. La première année, le rapport de son tuteur le montre ainsi: c'était un enfant intelligent qui avait besoin d'exceller et qui aimait à concourir là où il pouvait gagner, mais qu'on devait aider à développer sa faculté à perdre de bonne grâce et à partager. Il portait continuellement un «parka» qu'il avait sur lui en arrivant au camp, insistant pour le mettre même les jours les plus chauds, et il en arracha la laine, la nuit, durant les six premières semaines de son séjour au camp. A chaque visite de sa mère, il la traitait en étrangère pendant les quelques premières heures, et cependant devenait extrêmement bouleversé et pleurait abondamment quand elle le quittait.

La deuxième année nous le montra comme excessivement bavard, il semblait dominer toute conversation. Il avait apporté une énorme malle et deux sacs pleins d'équipement pour le camp, dont il ne se servit presque jamais. Son tuteur dut exiger que s'il revenait, sa mère n'envoyât que ce qui était suggéré sur la liste des vêtements du camp. Durant tout l'été, il eut l'air très actif, mais n'accomplit pas grand chose. Il manageait beaucoup et prit 8 livres en 8 semaines. Sa mère signala que beaucoup de ses lettres à lui—et elle lui écrivait chaque jour—furent retrouvées dans sa malle encore cachetées, à son retour à la maison.

Le troisième été, son jeune frère vint avec lui, parce que les parents allaient en Europe. Il passa beaucoup de son temps à surveiller les activités de son jeune frère, par conséquent fit peu en compagnie de son propre groupe. Notre attention fut attirée vers ce campeur quand, 10 jours avant la fermeture du camp, il vint nous voir en larmes, bouleversé, demandant à retourner chez lui immédiatement. Ses parents, de retour d'Europe, lui avaient téléphoné qu'ils ne pourraient pas venir le visiter en fin de semaine comme ils l'avaient promis, parce qu'ils avaient trop à faire à leur retour. Au lieu de cela, ils viendraient le voir à la clôture du camp pour le ramener à la maison. Je téléphonai aux parents, et en effet il leur était impossible de venir, mais ils viendraient la semaine suivante si je le jugeais nécessaire.

Les pleurs, l'expectative dans la tristesse, furent remplacés par un sentiment sans espoir, l'impression d'être pris au piège. Il commença à me soupçonner de vouloir le garder afin de toucher le prix entier de la période de camp; le camp était une prison, moi, le geôlier. Il essaya de bien des façons d'exciter la sym-

pathie des autres membres du personnel afin d'influencer ses parents ou moi. Un jour ou deux après, il développa d'abord des douleurs abdominales et la conviction d'avoir une hernie, puis, plus tard, la sensation de ne pouvoir respirer assez profondément et la peur d'avoir une pneumonie.

Des troubles de ce genre ne sont pas étrangers aux directeurs de camps et d'écoles, et au personnel des hôpitaux pédiatriques, dans les quelques premiers jours d'une séparation, mais on les rencontre rarement pour la première fois à la fin d'une troisième séparation. En récapitulant ce cas et son développement subséquent à la lumière de notre concept théorique, nous pouvons comprendre la dynamique de cette situation.

Sa mère avait été très tendue et incertaine durant la grossesse et les premiers stades du développement de cet enfant. Il eut des difficultés à prendre et à garder sa formule et la mère et l'enfant tous deux eurent une pneumonie au cours de la première année. Il possédait une couverture qu'il ne laissa jamais laver jusqu'au moment où il vint au camp. La situation maternelle pendant la première enfance avait été peu adéquate et ainsi la provision de bonnes choses était limitée. Il compensait par le succès et le besoin de gagner. Il eut à utiliser un «objet transitionnel», le parka, pour se défendre contre ses objets intérieurs coléreux et destructeurs. Quand sa mère visitait le camp, il avait été capable de se servir du camp comme le «tenant dans une situation», mais ceci seulement en réprimant l'image de la mère. Il lui fallait donc ne pas la reconnaître à son arrivée, tout en développant une crise émotionnelle quand il se sentait abandonné à son départ.

Le bavardage excessif constituait sa façon d'exagérer ses provisions de bonnes choses. La quantité excessive d'équipement en était la contrepartie extérieure. L'appétit énorme et le gain de huit livres, une façon d'amasser de bonnes choses. Ne pas ouvrir ni lire ses lettres lui permettait d'éviter la conscience de ses sentiments hostiles et son impression d'être abandonné. Son activité excessive ou mieux, sans but, était due à la négation maniaque de ses sentiments dépressifs.

Le troisième été, son intérêt et son souci concernant le bien-être de son petit frère représentait son identification avec le modèle de la bonne mère et lui était nécessaire à l'acceptation du départ de ses parents pour l'Europe. Son désappointement lorsque ses parents ne vinrent pas le voir à leur retour rendit bien plus évident son déséquilibre mental. Jusque-là, on ne l'avait pas considéré comme un problème, et ses activités étaient acceptées comme des variations chez un enfant de cet âge. Il s'était défendu avec succès contre ses intolérables sentiments dépressifs. Il ne put supporter son désappointement à la visite décommandée de ses parents et les sentiments dépressifs l'envahirent. Ils furent suivis par des défenses plus primitives contre la tristesse et la dépression, et prirent la forme de sentiments de persécution où je jouais le rôle de persécuteur. Ceux-ci furent à leur tour suivis par des troubles somatiques, lesquels semblent s'être développés en contre-coup de difficultés rencontrées dans la première enfance.

### Conclusion

À la lumière de ces observations sur le comportement infantile et les hypothèses émises sur le développement des émotions et relations d'objet, j'ai entrepris de décrire une façon d'envisager les angoisses à forme dépressive chez l'enfant, ainsi que quelques-unes des défenses qu'il mobilise contre elles. Je pense que ces anxiétés ont un rapport étroit avec certains états dépressifs de l'adulte, mais cet article ne cherche pas à en fournir la preuve. J'oserais espérer avoir con-

tribué à une compréhension sans cesse croissante des répercussions et des complexités du développement des états dépressifs chez les enfants comme chez les adultes; et je suggérerais de garder présents à l'esprit ces quelques principes au cours de l'examen d'enfants, d'adultes et de familles, dans l'espoir d'approfondir notre compréhension des états dépressifs.

### Summary

In this paper the author describes his findings in cases of homesickness which were studied in children's camp settings. The signs, symptoms, incidence and current theoretical concepts of depression and their defences in children are examined in considerable detail. A case illustration rounds out the presentation.

The author concludes by saying that in the light of these observations on childhood behavior and the hypothesis on the infant's development of object relations and emotions he has attempted to describe a concept of depressive anxieties in the child and some of the child's defences against these anxieties. He suspects that these anxieties are closely related to some of the adult depressive states, but states that his paper does not contribute to the proof of this suspicion. He hopes that it has made a contribution to increasing our understanding of some of the implications and complexities of the development of depressive states in both children and adults. He suggests that children, adults and families be examined with these concepts in mind in the hope that we may better our understanding of depressive states.



## *Clinical Report*

### **HIGH DOSAGE CHLORPROMAZINE TREATMENT IN CHRONIC SCHIZOPHRENIC PATIENTS**

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The effect of chlorpromazine in dosages considerably higher than normally used in psychiatric practice, was investigated on patients in a mental hospital. Reports of similar studies in this field have been published<sup>5,6</sup>. The group consisted of 53 female patients, 43 were chronic schizophrenics and 10 were in different diagnostic categories. Results concerning the latter group are not reported herewith.

The treatment began with 200 mgs chlorpromazine daily, given in 4 doses. This was increased weekly by 200 mgs and, barring dangerous complications, was continued until 2,000-3,000 mgs per day was reached. The tolerance of the patient dictated the dosage. The group was kept on this high dosage for 5-8 months.

Each patient underwent an examination before chlorpromazine therapy was instituted. This consisted of daily charting of blood pressure, temperature and pulse; weekly blood cell counts and urine analysis for bile and urobilinogen; monthly series of liver tests. As well as seeing the patients on the regular ward rounds, special interviews were held individually on a weekly basis for the first two months, and thereafter once a month until the end of treatment. Patients were not restricted in their ordinary routine.

In 8 months the largest total dosage was 429,000 mgs, the patient who received this had a daily dosage of 3,000 mgs. The smallest amount taken by an individual during the 5 month course was 68,000 mgs, the highest daily dose of this patient was 1,200 mgs. Most of the patients were getting small doses of chlorpromazine before this study began.

In the schizophrenic group the average age was 39.5 years. The youngest patient was 14 years old, the eldest 57. The average length of hospitalization of the group was 10.4 years, the shortest being 2 years and the longest 30.

Table I shows 20.9% of our patients were classified as "Remissions" and 39.5% as "Social Remissions", which made a total of 60.4% who could be discharged. It is customary to evaluate the outcome of treatment in studies similar to this one in terms of duration of illness. The meaning of such a procedure, however, is restricted. Among a group of patients who have spent approximately

TABLE I

| Duration of Illness | No. Patients | Remission    | Social Remission | Improved     | No Change     |
|---------------------|--------------|--------------|------------------|--------------|---------------|
| 0- 2 years          | 2            | 1            | 0                | 0            | 1             |
| 2- 5 years          | 8            | 0            | 6                | 1            | 1             |
| 5-10 years          | 10           | 4            | 2                | 1            | 3             |
| 10-30 years         | 23           | 4            | 9                | 5            | 5             |
| Totals:             | 43           | 9<br>(20.9%) | 17<br>(39.5%)    | 7<br>(16.2%) | 10<br>(23.2%) |

the same number of years institutionalized, there are differences in the severity of illness which may be measured, in one way by the level of deterioration. Consequently, it was decided to rate the patients using an index of deterioration rather than relying on comparisons made in conjunction with length of hospitalization. Arieti's system was used for this purpose<sup>1</sup>.

A brief description of different stages in schizophrenia is as follows:

The first phase of schizophrenia is characterized by anxiety or depressive mood, deeply affective delusions and hallucinations.

In the second or advanced stage anxiety diminishes or disappears, hallucinations and delusions become stereotyped, do not effect the activity of the patient. Thinking is more disconnected.

In the third or preterminal stage the patient's hallucinations or delusions become disorganized and lose emotional value. Thought content disintegrates, new habits like picking the skin, pulling out hair, rhythmic movements, hoarding and self decorating set in.

In the fourth or terminal stage there is no evidence of hallucinations or delusions. Speech is restricted to a few jumbled phrases. Food grabbing (tachyphagia), and swallowing of inedible substances (koprophagia) occurs. The patient appears insensitive to many stimuli, temperature, pain and taste.

TABLE II

| Grades of Deterioration | No. Patients | Remission    | Social Remission | Improved     | No Change     |
|-------------------------|--------------|--------------|------------------|--------------|---------------|
| 1.                      | 8            | 4            | 1                | 1            | 2             |
| 2.                      | 24           | 5            | 14               | 2            | 3             |
| 3.                      | 10           | 0            | 2                | 4            | 4             |
| 4.                      | 1            | 0            | 0                | 0            | 1             |
|                         | 43           | 9<br>(20.9%) | 17<br>(39.5%)    | 7<br>(16.2%) | 10<br>(23.2%) |

In our patients there was a 50% remission among those who were not deteriorated. The remission rate fell to 20% in the group with second grade deterioration. There was no remission among those classified in the third grade nor did the one patient in the terminal stage change with treatment.

It is interesting to note that almost 60% of those in the second grade of deterioration became well enough to be considered socially recovered. Among the patients in the third grade of deterioration 20% were in the "Social Remission" category, and 40% were in the "Improved" category.

TABLE III

| Sub-Groups of Schizophrenia | Patients | Remission | Social Remission | Improved | No Change |
|-----------------------------|----------|-----------|------------------|----------|-----------|
| Paranoid                    | 31       | 9         | 13               | 4        | 5         |
| Simplex                     | 10       | 0         | 4                | 3        | 3         |
| Hebephrenic                 | 2        | 0         | 0                | 0        | 2         |
| Totals:                     | 43       | 9         | 17               | 7        | 10        |

Analysing our results according to the schizophrenic sub-groups, we found remissions occurred only in the Paranoid group. There were no complete remissions among the Simple schizophrenic, but there were good social remissions. There were only 2 patients in the Hebephrenic sub-group. Both patients remained unchanged.

In one group the treatment produced a somewhat opposite effect to the one desired, i.e. the patients became greatly excited and could not sleep. However, after discontinuation of the treatment they were improved and were released. Consequently it has been our experience that the exacerbation of symptoms does not preclude the continuation of the chlorpromazine course. The hereditary background of the group was strongly loaded and their premorbid personalities, almost without exception, could be described as schizoid. Yet, we were able to discharge 16 patients, or 37.2%; 7 from the "Remitted Group", 8 from the "Socially Remitted", and 1 from the "Improved Group". Another 9 patients were suitable for discharge but had to remain hospitalized for administrative reasons. This would bring the total dischargeable to 60.4%, or 9 in the "Remitted Group", 15 in the "Socially Remitted" and 1 in the "Improved Group".

#### Laboratory Tests

There is little agreement concerning the effects of chlorpromazine on liver chemistry. While some authors have reported that when using routine liver function tests they were unable to detect any abnormality<sup>4</sup>, others such as Deutsch found mal-functioning livers in a little less than 50% of his patients<sup>5</sup>.

In all cases, after three to four months, the urine bile became positive and remained so for one to two months after discontinuation of treatment. The urobilinogen test became positive later, after bile was found in the urine, and remained positive to the end of the second or third month after discontinuation of treatment. There appeared to be a direct relationship between increased dosage and increased bilirubin, this was especially true in the case of the direct bilirubin. However, it became higher than 1 mg. in 2 cases only. In the cases where the direct bilirubin or total bilirubin was greater than 1 mg. the daily dosage was higher than 1,000 mgs. of chlorpromazine.

Thymol Turbidity and Cephaline Cholesterol Flocculation (CCF) tests were performed on all patients before treatment and during treatment with monthly intervals. 66% of all the CCF tests were positive before treatment, 41% of them were more than 2 plus. By the end of the treatment 57.6% of the positive CCF tests had become negative and in only 3 cases was this tendency reversed. 33% of the CCF tests were positive at the end of treatment, in comparison to the 66% positive before treatment.

To illustrate the improvement found in some liver function tests, the case of a patient who was given 194,900 mgs. chlorpromazine over 6 months of treatment is used as an example. Her Thymol Turbidity Test was 4 units prior to treatment. It progressively decreased month by month from 4 to 5.0, 3.5, 3.0, 2 finally reaching zero in the last testing. Her CCF test was 3 plus before treatment. Through the treatment it went from 2 plus, 2 plus, one plus to negative. There were cases where decrease was not so gradual, the liver function tests became negative suddenly and stayed negative for the duration of treatment. Three months after treatment was discontinued the liver condition of 20 patients was checked with a battery of tests, including total protein, alkaline phosphatase, A/G ration, Bromsulphthaleine, and Takata Ara. With the exception of one slightly positive Bromsulphthaleine test, all the tests were negative.

Comparing the results of the CCF test with clinical observation of patients involved, we found that of those whose liver function tests became negative or improved as well as those whose liver function tests showed no change from the original negative results, 85% were classified "Remitted" or "Socially Remitted". 5% of these patients were not considered improved. On the other hand, of those whose liver tests were positive before treatment and remained positive, or those whose liver tests became worse, only 33% were classified as "Remitted" or "Socially Remitted", 40% as compared to 5% of the above group were considered as failures.

Four months after treatment was discontinued CCF tests were repeated on some of the patients. In this rough spot-check we found two cases in which the symptomatological improvement was only temporary. The CCF tests of these patients, which had become negative during treatment, again became positive with exactly the same value as before the treatment was started.

It would be tempting to think along the same lines as those who have proposed a hepatotoxic theory of schizophrenia; (Platania, De La Vega, De Jong (2)). One cannot, of course, ignore the possibility that the liver abnormality is not the cause but the result of the schizophrenic conditions, brought about either directly by a change in the nervous system, or indirectly by the environmental conditions of the hospitalized patient which include, among other things, faulty eating habits, or unsatisfactory diet.

Although we do not pretend to answer this question on the basis of our study, we think that the role of the CCF test should be given greater consideration as a means of predicting the outcome of chlorpromazine treatment.

There was one case of Jaundice, which occurred during the first month of treatment at a dose of 600 mgs. daily. This was probably due to individual sensitivity.

### Summary

1. Chlorpromazine treatment was carried out with 53 female patients, 43 of whom were chronic schizophrenics. The dosage was high, up to 3,000 mgs. daily and the treatment lengthy, from six to eight months.

2. Among the chronic schizophrenic, remission occurred in 20% and Social Remission in 37% of the cases. Length of illness and grades of deterioration bear an inverse relationship to improvement.

3. Both paranoid and simplex schizophrenic patients benefitted from the treatment.

4. No permanent liver damage occurred. A large percentage of the previously positive CCF tests improved during the treatment and this was paralleled by psychological improvement.

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### Résumé

- 1) Le traitement à la Chlorpromazine fut appliqué chez 54 patientes dont 43 étaient des schizophrènes chroniques. Les doses données atteignèrent 3000 mgr par jour pendant une période de 6 à 8 mois.
- 2) Parmi les schizophrènes chroniques, une rémission survint dans 20% des cas et une rémission sociale apparue dans 37% des cas. La durée de la maladie et la gravité de la détérioration furent inversement proportionnelles à l'amélioration.
- 3) Les schizophrènes simples et paranoïdes bénéficièrent du traitement.
- 4) Il n'y eut pas de lésion hépatique permanente. Un haut pourcentage de patients montrèrent une amélioration parallèle entre les résultats du test C.C.F. et l'état clinique.



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### REPORT ON HOSPITAL AND MEDICAL INSURANCE PLANS



Since 1954 the Committee on Psychiatric Coverage in Hospital and Medical Insurance Plans has been following with interest the gradual improvement in the way in which the professionally sponsored prepaid medical care plans have provided insurance against the cost of the medical care of psychiatric disorders.

The summary of policies and practices of these plans as contained in this report is correct to September 1960. The committee feels that a comparison between this report and the first report prepared in 1954 shows encouraging progress. A summary of current hospital insurance practices concerning psychiatric illness will be reported at a later date.

J. D. Griffin, M.D.  
Chairman

Table 1 PSYCHIATRIC TREATMENT—Fees of the principal Canadian Pre-paid Medical Care Plans—1960

| Psychiatric Services & Fees  |                              |                            |  |                       |                |                        |              |   |                                   |             |   |  |
|--|------------------------------|----------------------------|--|-----------------------|----------------|------------------------|--------------|---|-----------------------------------|-------------|---|--|
| Name of Plan   | Referred Office Consltn. (a) | Unreferred First Visit (b) | Subsequent Office Visit (c)                                | House Calls           |                |                        | Hospital     |   | ECT                               |             | Insulin Hospital (k)                                  |  |
|  |                              |                            |  | First (d)             | Subsequent (e) | Nights & Holidays (f)  | Consltn. (g) | Visit (h)                               | Hospital (i)                      | Office (j)  |   |  |
| Medical Service Assn. Vancouver, B.C. (MSA)                        | 20.00                        | 10.00 same as for G.P.     | 5.00 for 15 min.<br>10.00 for 30 min.<br>20.00 for 60 min. | 8.00 same as for G.P. | 6.00           | 10.00                  | 20.00        | 4.00                                    | 5.00                              | 5.00        | 4.00  |  |
| Medical Services (Alberta) Inc. Edmonton, Alta. MS(A)I             | 25.00                        | 15.00                      | 7.50 for 30 min.<br>15.00 for 60 min.                      | 6.00 same as for G.P. | 4.00           | 8.00                   | 25.00        | 3.00                                    | 5 at 10.00 remainder at \$5.00    | same as (i) | 3.00 same as (h)                                      |  |
| Medical Services Inc. Saskatoon, Sask. MSI                         | 20.00                        | Not Covered                | N.C.   | N.C.                  | N.C.           | N.C.                   | 25.00        | N.C.                                    | N.C.                              | N.C.        | N.C.  |  |
| Group Medical Services Regina, Sask. GMS                           | 25.00                        | N.C.                       | N.C.   | N.C.                  | N.C.           | N.C.                   | 25.00        | N.C.                                    | N.C.                              | N.C.        | N.C.  |  |
| Manitoba Medical Services, Winnipeg, Man. MMS                      | 25.00                        | 15.00                      | 5.00   | 5.00                  | 5.00           | 6.00                   | 15.00        | 5.00                                    | N.C.                              | N.C.        | N.C.  |  |
| Physicians Services Inc. Toronto, Ont. PSI                         | 25.00                        | 15.00                      | 5.00 for psychotherapy<br>3.00 observation                 | 5.00                  | 5.00           | 6.00-10.00             | 25.00        | 3.00 if psychotherapy<br>3.00           | 5.00                              | 5.00        | 3.00 as(h)  |  |
| Windsor Medical Services Inc., Windsor, Ont. WMS                   | 10.00                        | 5.00                       | 3.00   | 6.00                  | 6.00           | 8.00 11 p.m. to 7 a.m. | 10.00        | 2.00 after prolonged hosp. care<br>3.00 | 5.00                              | N.C.        | 3.00  |  |
| Maritime Hospital Services Assoc. Moncton, N.B. MHSA (Blue Shield) | N.C.                         | N.C.                       | N.C.   | N.C.                  | N.C.           | N.C.                   | 10.00        | 3.00 unless ECT given                   | 15.00 first shk<br>5.00 subs q t. | N.C.        | as(h)   |  |
| Quebec Hospital Service Assoc., Montreal, P.Q. OHS                 | N.C.                         | N.C.                       | N.C.   | N.C.                  | N.C.           | N.C.                   | N.C.         | 3.00 per day up to 31 days              | N.C.                              | N.C.        | same as (h)   |  |
| Maritime Medical Care Halifax, N.S. (MMC)                          | 25.00                        | 5.00                       | 3.00 (one per week)  | 4.00                  | 4.00           | 5.00                   | 25.00        | 3.00 (no re- striction)                 | 15.00 (incl. Anes)                | 15.00       | Coma \$10 per treat- ment<br>Sub coma \$75 per course |  |

Table II  
**Psychiatric Treatment—Policies of Canadian Prepaid Medical Care Plans—1960**

| Name of Plan          | General Policy   | Services Excluded  | Maximum Liability  | Observations   |
|-----------------------|--|--|--|--|
| Medical Service Assn. | Preventive, diagnostic and therapeutic care  | Services rendered by public authority  | One year's treatment for any one illness. Psychotherapy limited to 15 sessions of one hour each                  | Whole question of incidence and cost of psychiatric treatment under review. Pattern of practice varies considerably. Psychiatric treatment of private patients increasing.   |
| MS(A/I)               | Preventive, diagnostic and therapeutic care  | Services rendered by public authority. In practice, attempting to keep as many patients as possible out of Provincial Mental Hospital and on private payment basis | One year's treatment for any one illness. As of Jan. 1/60 no maximum on fees collected for psychotherapy or ECT. | New <b>individual (non-group)</b> contracts provide one year waiting period for psychiatric treatment. Maximum liability of one year for one illness regarded as useful "because we can draw to the subscribers attention that they have exceeded their contractual rights and these limitations will be waived only if their demands are kept within reason." When cost in an individual case passes \$250 mark we send a form letter to psychiatrist requesting his views on prognosis. Sometimes case is then quickly terminated. Other times psychiatrist requests further treatment at MS(A/I) expense. |
| MSI                   | Preventive, diagnostic and therapeutic care  | Services covered without cost by Public authority, (i.e. all psychiatric treatment costs)  | One consultation unless very special case  | Adequate government services in province limits private practice of psychiatry. Beginning to apply co-insurance factor to conditions bordering on psychiatric care.  |
| GMS                   | Preventive, diagnostic and therapeutic care  | Services covered without cost by Public authority, (i.e. all psychiatric treatment costs)  | \$25 for initial psychiatric consultation per contract year  | A 1959 study in co-operation with MSI of cost of private psychiatric treatment has been completed. No change in policy of contracts has been made.   |
| MMS                   | Medical & Surgical services required for preventive, diagnostic and therapeutic care   | TB, VD, communicable disease and psych. disorders (except for diagnosis) and services supplied by public authority   | No limitation on office, home or hospital visitation.  | EST treatments not covered, but office, home and hospital visits are paid for on a specialist basis.   |
| P.S.I.                | Psychiatric care given in the office, home or hospital except where patient is an admitted bed patient in a special mental hospital or institution not including psychiatric wings of gen. hosp. | Services provided by public authority and in public hospital for mental disease (Drug addiction, alcoholism, epilepsy) TB  | Psychiatrist receives only \$5.00 for psychotherapeutic interview but may bill patient separately for balance    | Plan may request approval of psychotherapy by Executive Committee. This has actually been invoked in very limited number of cases. Plan believes it pays about 60% of total psychiatric bill.  |
| WMS                   | Medical Services for preventive, diagnostic and therapeutic care. Psychiatrists are not participating physicians. May therefore extra-bill   | Conditions covered by public authority, including mental disease, alcoholism, drug addiction, epilepsy where patient is in public mental hospital.                 | Only limits are arbitrary. Plan decides solely from its own information the appropriate amounts to allow.        |  |

| Name of Plan  | General Policy  | Services Excluded   | Maximum Liability   | Observations   |
|---|---|---|---|--|
| MMC   | Psychiatrists are participating physicians. Subscribers' contracts provide for extra-billing by specialists   | Care provided by public authority or when subscriber is put under care of hosp. for TB, MI, Alcoholism, Epilepsy or as a Drug Addict (or should be). Does not pay for certification papers to Mental Hospital. Re M.I. hosp. must be special or Govt. Inst. before exclusion applies (i.e. institution which provides free treatment) | None  | "There is a restriction on office psychotherapy to one visit per week, dictated by financial considerations in view of long duration of this type of treatment."   |
| MHSA  | Benefits limited to providing services of psychiatric specialist while subscriber is patient in participating general hospital recognized as qualified to provide hospital service for such illness   | Alcoholism, drug addiction, epilepsy, intentional self-injuries "whether sane or insane", Anaesthesia for shk treatments. Complications relating to pregnancy   | One consultation in any 12 month period. Psychiatric treatment for first 30 days only or hospital care in approved general hospital and 70 days only in life of contract.   |  |
| QHSA  | Benefits limited to physicians fee for treatment in hospital from 31 to 70 days depending on type of contract   |   |   | In-patient care also provided under Extended Health Benefits Program up to \$5,000 or \$10,000. Patient pays first \$100 and plan pays 75% or 80% of expenses incurred.  |
| Group Surgical-Medical Insurance Plan, Dept. of Finance, Ottawa | Provides: —<br>1) Surgical Expense benefits plus anaesthetists fee (according to fee schedule)<br>2) Diagnostic laboratory and X-ray benefits<br>3) Major Medical Expense benefits (80% of expenses over (1) plus (2) plus deductible of \$25.00 to \$50.00 | Services not approved by duly licenced physician or surgeon. Services rendered without charge by Public Authority (i.e. DVA, mental hospitals, etc.)  | Maximum amount under major Medical Expense benefit \$5000 for one individual during his lifetime. If after \$1000 has been paid in respect to one individual recovery takes place, individual maximum of \$5000 will be reinstated. | Pays 80% of amount by which total expenses in a calendar year of the participant exceed the sum of:<br>a) the amount paid under the Surgical Benefits (set fee scale) plus<br>b) the amount deductible (\$25 for individual, up to \$50 for family). Eligible expenses include services of psychiatrists and psychotherapists. |

## *Proceedings of the 10th Annual Meeting*

### CANADIAN PSYCHIATRIC ASSOCIATION

The Tenth Annual Meeting of the Association was held at the School of Fine Arts, Banff, Alberta at 2 p.m. on Friday, June 17th, 1960.

Approximately 50 members were present for the annual business meeting. The President, Dr. Lawson was in the chair.

The President called the meeting to order:

#### **Minutes of the Last Annual Meeting**

It was moved by Dr. Griffin that these be accepted as read. This was seconded by Dr. Stokes and the motion was carried.

#### **Report of the Board of Directors**

I have the honour to present the Annual Report of your Board of Directors. This report will follow the pattern established last year and while only a few reports of committees will be presented at this meeting today you are invited to ask questions about our various activities and to express your views on matters of interest so that the Board will have the benefit of your opinions and views during the coming year.

Since the last Annual Meeting, the Board of Directors has held four meetings. The increased number of meetings, the improved attendance at these meetings, and the duration of each meeting are all indications of the increasing scope of our activities. The Board is concerned with all of those things which affect the standard of care given to our patients, with our relationships with other members of medical and other professional groups, and with those things which affect the rights and privileges and responsibilities of our individual members. The Association exists to serve its individual members and can only do this effectively with the support and participation of each and every psychiatrist in this country. Your Board is most anxious to see a further strengthening of your Association and hopes that it will be possible to further improve the association between C.P.A. and provincial organizations. The Board is anxious to record and acknowledge the active support given by Committee Chairmen and Committee members without which it would be impossible for your Association to function. The time and effort they so willingly give to further the development of psychiatry in Canada is most important and we all owe them a debt of gratitude.

The first meeting of this Board was held in Halifax on June 6, 1959. All of the officers, eight directors, one alternate and four committee chairmen were in attendance.

The second meeting was held in Toronto, March 10, 1960. Four officers, seven directors, three alternates and eight committee chairmen were present.

The third meeting was held in Ottawa, April 21, 1960. All of the officers, four directors, one alternate and nine committee chairmen were in attendance.

The fourth meeting was held in Banff in June 15, 1960. Four officers, five directors, three alternates and seven committee chairmen were in attendance.

Members will recall that the reports of last year's annual meeting were published in the Journal. The Editor in cooperation with the Board is developing a policy whereby important committee reports and other items of business will be carried in the Journal so that the membership at large may be kept aware of the matters currently receiving attention. If subsequent recommendations regarding the organization of the Association are accepted it is hoped to establish a regular newsletter which will further improve communication throughout our Association.

The activities and programs of various governmental authorities have been carefully reviewed during the year and certain action has been taken by your Board. On three occasions delegations from the Association have met with federal authorities. Two of these meetings was with the Minister of National Health and Welfare and the third with authorities in the Department of Justice and Medical Immigration Service.

The Board has recommended a strengthening of federal activities in our field. It has been suggested that the status of the senior consultant in psychiatry should be raised and that all federal activities should be coordinated.

We have continued to press for changes in the Federal-Provincial Hospital Insurance programme. Delegates of the Association had a very satisfactory meeting with the Honourable Mr. Monteith but while he appeared sympathetic to our position, no further developments have taken place.

There has been continuing concern with the immigration regulations and procedures and with the Criminal Code as these respect mental health. Satisfactory liaison has been established with the appropriate federal authorities and it is hoped that improvements will ensue from our continuing efforts in this direction. In connection with these matters our Honorary Counsel, Dr. Gray, has been most helpful.

At the national level, we have been increasingly conscious of our relationships with other organized groups. As the members are aware, we are an affiliate of the C.M.A. and in this connection we have a delegate on the General Council of C.M.A. and are looked on by that body as the advisory group on all matters related to psychiatry and mental health. The C.M.A. has officially approached the Minister of National Health and Welfare to support our brief on Hospital Insurance. We are also exploring with them all other matters—e.g. mental health services, immigration, criminal code—in the anticipation that we will gain their support for any reasonable and justifiable requests for action. We also have a Liaison Committee which meets with C.M.A. representatives periodically and discusses matters of mutual interest—during the past year they have been concerned with undergraduate education in psychiatry, L.M.C.C. examination, continuing education for general practitioners, as well as other matters mentioned earlier. All in all, our relationships with C.M.A. have been very satisfactory and it appears to your Directors that a strong C.P.A. working with C.M.A. provides the best opportunity for psychiatry to establish its needs and to promote necessary action to accomplish our objectives.

Several years ago, the C.M.H.A. asked us to name a delegate to their S.P.C.—Dr. Chalke was our delegate during the past year. Some members have expressed concern about the relationship of these two bodies but your Board of Directors feel that the interests of psychiatry and of the lay organization can best be studied, promoted and developed by a continuation of this relationship.

Some of our members may not be aware of our relationship with the Royal College of Physicians and Surgeons. Since our organization was formed, we have been regularly asked to nominate the members of the Royal College of Physicians and Surgeons Committee on Psychiatry and to date our nominations have been always accepted. Our communication with the Royal College takes place in a number of different ways—at times there are official exchanges of correspondence, at other times our Committee on Psychiatric Education establishes contact with appropriate committees or members of the R.C.P.S. and the members of the R.C.P.S. Committee on Psychiatry are continuously striving towards the accomplishment of our aims.

At the international level, our relationships are also becoming increasingly important. Our Association is co-sponsoring the Third World Congress of Psychiatry in Montreal in June 1961 with McGill as the host organization. The Chairman of the Organizing Committee will make a more detailed statement regarding this Congress later in the meeting. The Board of Directors has also approved the holding of a reception for members of the Congress on Sunday, June 4, 1961.

For some years, relationships of C.P.A. and A.P.A. have been under review. Last year the A.P.A. suggested the establishment of a liaison committee to study our mutual activities. The Board of Directors has appointed Dr. Stokes and the Secretary as the representatives of C.P.A. with three specific directives—(1) The A.P.A. should not concern itself with Canadian socio-political affairs (2) The idea of reciprocal membership should be explored and (3) to consider all other matters of mutual interest. Members may rest assured that no commitments will be entered into without approval of the membership of C.P.A. Most of our members will have heard of the A.P.A. B.C. Survey in which our Association has been intensely interested. The members of your Board of Directors now feel that satisfactory developments are taking place.

During the year, a request was received from the Association of Mental Hospital Chaplains—Quebec-Ontario Division—for liaison with this Association. As we do not provide for such arrangements, the A.M.H.C. was advised that we would be glad to have their members attend our scientific sessions and that we would work with them in connection with matters of mutual interest.

From time to time, the Board of Directors has been concerned with statements to the effect that C.P.A. is not an active organization and such quotations as "What does C.P.A. do for us?" The earlier parts of this report have indicated the direct activities of your directors. We now pass to other activities where the Board provides opportunities for membership participation and opportunity for members to express their ideas and to participate in the formulation of policies and in the development of areas of special interest.

The Journal will be reported on in detail by the Editor. This Journal has been established to provide a voice for Canadian psychiatry — more extensive use should be made of letters to the Editor and the Journal should be read as well as used for a media for the publication of articles. We have had complaints from certain members that they are unaware of certain committees and yet all of these have been published during the past year in the Journal. Certain special reports have also been published but relatively few members have written to the officers, directors or committee chairmen about these matters. Our Editor, Dr. Chalke, is giving a great deal of his time and energy to the development of this Journal but he requires active support and participation from the membership. The matter of size and frequency of issues of the Journal will be dealt with later in this meeting.

During the year the following committees have been active:

- Ad Hoc Committee on Standards Accreditation
- Mental Retardation
- Child Psychiatry
- Hospital and Medical Care and Insurance for Psychiatric Patients
- Research
- Psychiatric Education
- Medical Economics

The reports of these committees are available.

The Ad Hoc Committee on Standards and Accreditation has been developing relationships with the Canadian Council on Accreditation and the development of standards for mental hospitals. The Directors have approved the preliminary statement of standards and it is hoped that the Council will begin its program of accreditation next year. Dr. McNeel and his Committee have done a terrific amount of work in connection with these matters and our members will be more aware when the completed standards are available.

The Committee on Mental Retardation chaired by Dr. Frank has studied three major areas of concern — the accreditation of mental retardation facilities, training in undergraduate medical education, and the training of psychiatrists in this field.

In the near future, the Committee on Insurance Coverage chaired by Dr. Griffin will make available a complete survey of the present situation in Canada.

The Committee on Research chaired by Dr. Sloane is studying the financing and organizing of psychiatric research. We are concerned with ways and means of increasing the funds available and improving the opportunities for career development in this area of work.

Our Committee on Psychiatric Education with Dr. Jones as Chairman is presently studying the possible future developments with regard to certification and fellowship examinations, the approval of facilities for postgraduate training, and the establishment of an L.M.C.C. examination in psychiatry.

The Committee on Medical Economics chaired by Dr. Tyhurst has been studying fee schedules and remuneration for psychiatrists on a salaried, part-time or sessional basis. Certain specific recommendations have been made and will be further studied by your Board of Directors.

The Committee on Child Psychiatry has held a very successful meeting again this year and other items in connection with this Committee will be subject to later consideration.

The Constitution Committee chaired by Dr. Stokes has been concerned with a number of important matters. The first of these is the important one of C.P.A. provincial association relationships and Dr. Stokes has been authorized to study this matter in detail with the hope that a stronger C.P.A. based on close liaison and relationships with local psychiatric associations will be developed. He will be writing and visiting provincial groups during the coming year to permit a cooperative study of this matter. The Board of Directors hopes to make the National Association fully representative and capable of reflecting the views of psychiatrists right across Canada. In this respect, it is also hoped to provide for more effective representation on the Board of Directors particularly with regard to alternates having the power to vote.

The report of the Membership Committee will be presented separately.

A number of specific items have also been receiving consideration. Members are fully aware of the Tyhurst Committee of C.M.H.A. which is studying mental health services in Canada. It is planned to hold a second Canadian Mental Hospital Institute in Ottawa during 1961 to provide an opportunity for a full and comprehensive consideration of the report of the Tyhurst Committee.

Recently we were invited to have a delegate at the annual meeting of the R.M.P.A. and Dr. D. Ewen Cameron has agreed to accept this responsibility.

The International Classification of Diseases has also come under review. At our request, Dr. Goddard was appointed to the Subcommittee on Statistics of the Mental Health Advisory Committee of the Department of National Health and Welfare which will be considering the Canadian position in respect of the international classification when it is next considered for revision. It is anticipated that the Committee on Child Psychiatry will cooperate with Dr. Goddard in this matter. We have also had preliminary contact with A.P.A. in the hope that it may be possible to develop one classification for future use.

Questions have arisen regarding the participation of professional groups, such as nurses, psychologists, social workers, and others at our annual meetings. The Directors have established a policy which permits individuals from these professional groups to register on payment of a fee and to participate in all activities except business meetings.

Having reviewed our present activities, the Board of Directors would now like to deal with the future development of activities of your Association. The need for a strong voice to express our views and needs during this period of increased governmental and other activities in the health field is apparent. A strong voice can only be developed if we have the necessary financial means. Many requests have been made for expansion of the Journal and for the strengthening of our Association activities. Members are well aware of the present dependence of our Association on the voluntary activities of a relatively small group of psychiatrists. Our Association can only be strengthened and expanded if the officers have available to them adequately paid staff and office facilities.

The present fee structure only provides for the following budget:

|                                     |                   |
|-------------------------------------|-------------------|
| Income 611 members at \$10.00 ..... | 6,110.00          |
| Expenditure—Journal                 |                   |
| 611 at \$4.00 .....                 | 2,444.00          |
| Travel for President .....          | 1,500.00          |
| Office Rent .....                   | 300.00            |
| Secretarial and Clerical Help ..... | 500.00            |
| Other office expenses .....         | 500.00            |
|                                     | <u>\$5,244.00</u> |

Leaving a balance of \$866.00 for all other purpose including some \$200.00 for the annual convention.

Your Board of Directors proposes the following budget:

|   |                    |
|---|--------------------|
| Journal 600 at \$10.00 .....              | 6,000.00           |
| President's Travel .....                  | 1,500.00           |
| Executive Secretary .....                 | 5,000.00           |
| Office Expenses (including rent) .....    | 2,000.00           |
| Secretarial and Clerical Assistance ..... | 3,000.00           |
| Directors Meetings .....                  | 4,000.00           |
|   | <u>\$21,500.00</u> |

The above would permit the establishment of an adequate central office, proper facilities for committees, a monthly newsletter, and other necessary services, and a Journal published at least six times per year.

To accomplish this with our present membership will involve a fee in excess of \$30.00 per annum. Allowing for anticipated growth and with our present small reserves, it is felt that the Association can be adequately financed for the next several years on the basis of \$35.00 per member.

Your Board of Directors recommends the establishment of a fee of \$35.00 per annum for active members and \$10.00 per annum for associates.

The Board of Directors has also considered the report of the Committee on Child Psychiatry to be presented by Dr. Taylor Statten this afternoon and recommends its acceptance for a period of one year during which the Constitution Committee will study constitutional means of providing for this and other specially interest groups.

In conclusion, I would personally like to express my appreciation of the cooperation I have received from the membership and I regret that the financial resources available to date have not permitted the development of more adequate services and activities for your Association.

This report was presented by Dr. C. A. Roberts, Secretary. In discussion of the report the following were considered.

(a) Particular emphasis was placed on our discussions with the Federal Government concerning

- (i) Consultant to the Mental Health Division, Department of National Health and Welfare (brief presented)
- (ii) Hospital Insurance (brief presented)
- (iii) The Criminal Code
- (iv) Immigration procedures

Dr. Jones made a motion approving these briefs, expressing the thanks of the Association to the members who were involved in these discussions.

Dr. Bos seconded, the motion was carried.

(b) Appointment of the Liaison Committee with A.P.A. Dr. Coburn made a motion approving these appointments, Dr. Griffin seconded. Motion was carried.

(c) Increasing Annual Fee. Dr. Sloane made a motion that we increase our fees for full members to \$35.00 per annum and \$10.00 per annum for associate members. Dr. Yonge seconded. Dr. Stokes spoke to the motion. There were suggestions from the floor that this annual fee might well do away with registration fees for the annual meeting. It was also suggested that a newsletter be sent to our various members explaining the increase in fees. Dr. van Nostrand elaborated on the need for a \$35.00 fee as did Dr. Roberts and Dr. Lawson. At Dr. Scott's requests, Dr. Chalke outlined the Journal's need for increased support from the Association. The motion was voted on — 32 approving, 4 abstaining, no negative votes.

Dr. Cameron then moved adoption of the Secretary's report, Dr. Yonge seconded and the motion was carried.

\* \* \* \*

### Treasurer's Report

This report including the Auditor's report, was tabled by Dr. Roberts in Dr. Hamilton's absence.

#### Statement of Operation

1959

#### Bank Reconciliation:

|  |          |
|--|----------|
| Bank Balance as per Bank Statement 31 Dec. 1959..... | 4,020.30 |
|--|----------|

#### Statement of Receipts and Disbursements:

|                                  |            |
|----------------------------------|------------|
| Balance as at Dec. 31, 1958..... | 3,178.84   |
| Receipts for year 1959.....      | 4,362.17*  |
|                                  | 7,541.01   |
| Expenditures for year 1959.....  | 3,520.71   |
| Balance as at Dec. 31, 1959..... | \$4,020.30 |
| Revenue 1959.....                | 4,362.17   |
| Expenditures 1959.....           | 3,520.71   |
|                                  | \$ 841.46  |

|  |          |
|--|----------|
| * (a) receipts relating to C.P.A. convention (Ottawa)..... | 1,565.57 |
|--|----------|

|  |          |
|--|----------|
| (b) receipts for Membership fees 1959..... | 2,796.60 |
|--|----------|

|  |            |
|--|------------|
|  | \$4,362.17 |
|--|------------|

#### Certificate:

I have audited the books and accounts of the *Canadian Psychiatric Association* for the year ended December 31, 1959, and certify that the balance sheet is, in my opinion, drawn up so as to show a true and correct view of the affairs of the Association as at December 31, 1959, according to the best of my knowledge, information submitted to me and as shown by its books of account.

T. E. Dancy, M.D.  
Auditor,  
Canadian Psychiatric Association.

Signed,  
Albert Guenette,  
Treasury Representative,  
Ste. Annes Hospital  
Ste. Anne de Bellevue, P.Q. (Canada)

Dr. Roberts moved its acceptance, Dr. Dewan seconded, the motion was carried.

\* \* \* \*

### Journal Report

This report was tabled by the Journal Editor, Dr. Chalke.

1. The Journal was published quarterly in 1959 with, in addition, a special supplement reporting the proceedings of the Conference on Depression and Allied States held at McGill University in March 1959.

The regular issues published 25 scientific papers, of which 8 were in French, the balance in English.

2. An effort has been made to shorten the length of some of these papers and this has been partially successful, permitting more prompt publication, as clinical notes, of up to date drug trials and assessments.

3. It was decided by the Board of Directors in 1959 that the proceedings of the annual general meeting be published but that only those committee reports considered by the Board to be of general and timely interest be published in various issues during the year.

4. The editorial board and Dr. Christie, the assistant editor, and the Editorial Assistant have all rendered inestimable service in their own special fields.

5. It is with regret that we recommend acceptance of the resignation of Dr. Marcel Berthiaume as Assistant Editor. Dr. Berthiaume has carried out his tasks of editing of the French section and the translation of summaries faithfully and well and has been a loyal colleague during the difficult initial years.

### Editorial Management Committee

1. An audited statement for the year 1959 was tabled.

2. With the change in financing which took place last year a deficit in the year's operation of \$700.00 was anticipated and the Board of Directors authorized, in March 1959, that funds be set aside up to \$750.00 to meet this expected deficit.

3. It will, however, be noted that the deficit was \$1,212.32. Several items were responsible for this discrepancy:

(a) A marked increase in printing costs;

(b) An error in the previous year's audit by which an account receivable of \$500.00 (for reprints) was not balanced against our account payable to the printer for these reprints;

(c) An account payable on the previous year's operation of \$103.00 which was overlooked.

(d) The auditors' bills for 1958 and 1959 audits were not received until 1959 and therefore both paid in 1959 (\$200.00).

4. The emergence of the above facts has led to a revision of the 1960 operating budget (which was approved at the 1959 Annual Meeting as follows):

#### Expected Revenue

|  |                    |
|--|--------------------|
| C.P.A. Membership Grant (at \$4.00 per member).....  | \$ 2,444.00        |
| Non-membership subscriptions .....   | 600.00             |
| Advertising Revenue (net) \$6,900. Gross less 17% commission to advertising agents payable on most advertisements: \$1,173. .... | 6,400.00           |
| Sale of reprints .....   | 1,000.00           |
| <b>TOTAL</b>   | <b>\$10,344.00</b> |

#### Expected Expenditure

|  |                    |
|--|--------------------|
| Salary — Editorial Assistant .....   | 1,600.00           |
| Printing and mailing of Journal .....  | 6,400.00           |
| Reprints .....   | 1,000.00           |
| Rent — Office .....  | 600.00             |
| Office operation, audit, postage, telephone, telegraph, and bank charges in 1959 came to \$783.27 (in 1957 they were \$334.96) ..... | 600.00             |
|  | \$10,200.00        |
| Less \$300.00 credit from Runge Press on 1959 printing .....   | 300.00             |
| <b>TOTAL</b>   | <b>\$ 9,900.00</b> |

5. With the proposed increase in membership subscription arising from the newly adopted fee schedule the increased frequency of publication of the Journal will be explored. A suggested budget for 1961 is as follows:

|                          |             |                          |             |
|--------------------------|-------------|--------------------------|-------------|
| Income: Fees .....       | 6,000.00    | Expenses: Salaries ..... | 4,000.00    |
| Other subscriptions .... | 1,500.00    | Rent .....               | 600.00      |
| Reprints .....           | 1,000.00    | Printing .....           | 10,000.00   |
| Advertising .....        | 8,400.00    | Reprints .....           | 1,000.00    |
|                          |             | Office .....             | 700.00      |
| Total                    | \$16,900.00 | Total                    | \$16,300.00 |

Dr. Chalke moved acceptance of his report. Dr. Griffin seconded. The motion was carried.

### Report of Membership Committee

In Dr. McNair's absence, Dr. Roberts tabled this Committee's report. It was drawn to the attention of the meeting that as many as 500 Canadian psychiatrists were not members of the Association.

Five hundred and eighteen letters to prospective members have been sent out from this office in the course of the year. There has been a total of seventy-nine applications approved, four of which were from associate to full membership and one of which was from full membership to inactive status. One application was turned down due to the fact that the doctor applying is no longer actively practicing psychiatry and does not take part in any of the psychiatric activities in the area where he resides. Other general correspondence totalled twenty-seven letters.

We have been very pleased with the results of the new application form which asks for a printed signature as well as a written one. This has dispensed with the previous delay caused when we had to write to the applicant asking him to identify one of the signatures on his application.

I wish to express my thanks to yourself and to the members of my committee, Dr. Alastair MacLeod and Dr. Yves Rouleau for assistance given.

#### MEMBERSHIP JUNE 1, 1960

|                      | Total<br>1959 | Total<br>1960 | Members | Associate | Life | Inactive | Honorary |
|----------------------|---------------|---------------|---------|-----------|------|----------|----------|
| Newfoundland         | 15            | 15            | 9       | 6         | —    | —        | —        |
| Prince Edward Island | 3             | 3             | 3       | —         | —    | —        | —        |
| Nova Scotia          | 21            | 20            | 18      | 2         | —    | —        | —        |
| New Brunswick        | 18            | 16            | 16      | —         | —    | —        | —        |
| Quebec               | 118           | 134           | 125     | 9         | —    | —        | —        |
| Ontario              | 231           | 249           | 235     | 7         | 4    | 1        | 2        |
| Manitoba             | 20            | 24            | 23      | —         | 1    | —        | —        |
| Saskatchewan         | 45            | 42            | 37      | 5         | —    | —        | —        |
| Alberta              | 26            | 28            | 28      | —         | —    | —        | —        |
| British Columbia     | 39            | 43            | 40      | 1         | —    | —        | 2        |
| Other                | 536           | 574           | 534     | 30        | 5    | 1        | 4        |
|                      | 32            | 37            | 36      | —         | —    | —        | 1        |
|                      | 568           | 611           | 570     | 30        | 5    | 1        | 5        |

#### DECEASED

Byrne, U.P.  
Montgomery, S.R.P.

#### LIFE MEMBER

Howitt, J.R.  
Pincock, T.A.  
Cathcart, J.P.S.  
McIntyre, A.J.  
Chalk, S.G.  
Richardson, R.B.

#### HONORARY

Farrar, C.B.  
Hincks, C.M.  
Crease, A.L.  
Chisholm, B.  
Ebaugh, F.

#### INACTIVE

Sauriol, L.E.

|                |                         |
|----------------|-------------------------|
| Deaths         | 2                       |
| Resigned       | 9                       |
| Members        | 46 (10 from Associates) |
| Associates     | 22                      |
| Life           | 5 (from Active)         |
| Inactive       | 1 (from Active)         |
| Total Changes; | 85                      |

Dr. Roberts, in making a motion to accept this report, on behalf of the Association thanked Dr. McNair and his Committee for their efforts on our behalf. Dr. Van Nostrand seconded. The motion was carried.

\* \* \*

### **Report of the Committee on Child Psychiatry**

Dr. Taylor Statten as Chairman of this Committee presented its report. Reference was made to the fact that this had been considered by the Board of Directors and had been approved. The terms of Reference were referred to the Annual Meeting for consideration. *Committee on Child Psychiatry, Terms of Reference*

1. The Child Psychiatry Group shall be recognized by the C.P.A.
2. The members of the group shall be those members of the C.P.A. who signify their interest in Child Psychiatry.
3. The Child Psychiatry Group shall submit a list of members to the Board of Directors of the C.P.A. with the recommendation that they be appointed as a Standing Committee on Child Psychiatry.
4. The functions of this Committee shall be as follows:
  - (a) To arrange meetings at the time of the Annual General Meeting and other times for the discussion of papers concerning the problems of Child Psychiatry. Those meetings to be open to all members of the C.P.A. and to guest members of the Association.
  - (b) To prepare memoranda concerning Child Psychiatry for discussion within the group or with Committees of the Association.
  - (c) To assure and strengthen the close and continuing relationships between those interested in the various aspects of Child Psychiatry and the C.P.A.
  - (d) To arrange with the approval of the Board of Directors of the C.P.A. professional scientific meetings and to stimulate the presentation of papers on Child Psychiatry within other organizations with related interests.

Dr. Taylor Statten moved that they be accepted, Dr. Scott seconded, and the motion was carried.

\* \* \*

### **1961 Meeting of the Canadian Psychiatric Association**

Dr. Roberts reported that this would take place in Montreal, June 3 and 4. On June 3 there would be a Board of Directors Meeting and the annual business meeting of the Association June 4. Also that the Association would hold a reception on June 4 entertaining overseas psychiatrists attending the World Congress.

\* \* \*

### **World Congress of Psychiatry**

Dr. Cameron reviewed the progress of preparations and plans for the World Congress.

\* \* \*

### **Report of Nominating Committee**

Dr. Thomas being absent, Dr. Roberts tabled the report from this Committee and moved its acceptance. Dr. Jones seconded, the motion was carried.

\* \* \*

### **Report of Scrutineers**

Dr. Scott tabled this report and the President, Dr. Lawson, declared Dr. Saucier the President-Elect.

\* \* \*

### **Adjournment**

There being no further business, Dr. van Nostrand moved that the meeting be adjourned, seconded by Dr. Hanley. Carried.

## CHAIRMEN OF COMMITTEES &amp; DELEGATES C.P.A. 1960-61

|  |  |
|--|--|
| <i>Delegate to Canadian Medical Association</i> . . . . .        | Dr. F. S. Lawson   |
| <i>Delegate to Canadian Mental Health Association</i> . . . . .  | Dr. D. G. McKerracher  |
| <i>Auditors</i> . . . . .  | Dr. T. E. Dancey<br>Mr. Albert Guenette  |
| <i>Scrutineers</i> . . . . .                                     | Dr. T. E. Dancey<br>Dr. W. C. M. Scott   |
| <i>Committee on Psychiatric Education</i> . . . . .              | Dr. R. O. Jones, Chairman<br>212 Robie Street, Halifax, N.S.   |
| <i>Constitution Committee</i> . . . . .                          | Dr. A. B. Stokes<br>2, Surrey Place, Toronto, Ont.   |
| <i>Journal Management Committee</i> . . . . .                    | Dr. F. C. R. Chalke, Editor  |
| <i>Ad Hoc Committee on Rehabilitation</i> . . . . .              | D. Geo. Sisters<br>Union of Manitoba, Winnipeg   |
| <i>Ad Hoc Committee on Standards and Accreditation</i> . . . . . | Dr. B. H. McNeel, Chairman<br>Mental Health Division,<br>Ontario Department of Health,<br>Toronto, Ontario |
| <i>Membership Committee</i> . . . . .                            | Dr. F. E. McNair, Chairman<br>4450 Grandview Highway   |
| <i>Committee on Child Psychiatry</i> . . . . .                   | Dr. Taylor Statten, Chairman<br>Montreal Childrens' Hospital   |
| <i>Ad Hoc Committee on Mental Deficiency</i> . . . . .           | Dr. H. F. Frank, Chairman<br>Ontario Hospital School<br>Smiths Falls, Ontario                              |
| <i>Committee on Research</i> . . . . .                           | Dr. R. B. Sloane<br>Department of Psychiatry<br>Queen's University,<br>Kingston, Ontario                   |
| <i>House Committee</i> . . . . .                                 | Dr. Angela Heffernan, Chairman<br>300 Cooper Street,<br>Ottawa, Ontario                                    |
| <i>Liaison Committee C.M.A./C.P.A.</i> . . . . .                 | Dr. D. G. McKerracher, Chairman<br>University of Saskatchewan,<br>Saskatoon, Sask.                         |
| <i>Economics Committee</i> . . . . .                             | Dr. R. H. Tavener,<br>Selkirk Mental Hospital,<br>Selkirk, Manitoba  |
| <i>Budget Committee</i> . . . . .                                | Dr. C. A. Roberts,<br>6825 Lasalle Blvd., Outremont,<br>P.Q.   |
| <i>Nominating Committee</i> . . . . .                            | Dr. C. A. Cleland  |
| <i>Ethics, Public Relations and Information</i> . . . . .        | Dr. A. Miller<br>999, Queen St., Toronto, Ont.   |

## *Book-Reviews*

**Institutional Neurosis.** Russell Barton: With a foreword by Noel Gordon Harris. Bristol. John Wright & Sons Ltd., 1959 (56 p.)

It is now a well-known fact that collective settings, such as prisons, TB hospitals, orphanages, etc., often exert a pathogenic influence on their inmates. It would be extraordinary if mental hospitals would be the only exception to that rule. However, in mental hospitals such disturbances are naturally apt to be confused with the symptoms of the mental illness proper. To distinguish what, in the clinical picture shown by the inmates of mental hospitals, belongs to the original disease or what is a reaction to the setting, requires from a physician a more than average lucidity and intelligent honesty.

Dr. Barton endeavours to describe "the dreadful mental changes that may result from institutional life and the steps that can be taken to cure them." His booklet is clear, convincing and excellently written. However, we have two criticisms:

(1) It was of course the right of the author to restrict his topic to his personal observations and experiences in one particular hospital during a certain period of time. As such, his book is a valuable contribution. But if he also decided to give a historical introduction he should have started his survey long before Myerson. Already Pinel demonstrated that the mental condition of mental patients improved after their chains had been removed. Due credit should have been given to Hermann Simon, in Germany, who proclaimed that many "schizophrenic" symptoms were but a response to faulty mental hospital conditions and proved it by his method, published shortly after World War I. After World War II, French psychiatrists performed pioneer work in the same field. The bibliography gives the false impression that nothing was ever done outside of English-speaking countries.

(2) It is questionable if there is just "one" condition—whether one calls it "institutional neurosis" or gives it another name. There is good reason to assume that there are a variety of reactions—neurotic, psychotic, psychopathic, etc.—to the mental hospital setting. The author's description shows a mixture of these reactions, with special emphasis on the neurotic (similar to the "barbed-wire disease" in prisoners of war). Among the pathogenic factors, there are certainly more than the seven enumerated by the author.

The best part of the book is the one concerned with the treatment of institutional neurosis. Here Barton shows his great experience and gives extremely good and useful advice. It is to be wished that his book will be widely read and taken as a starting point for other studies and therapeutic undertakings.

H. ELLENBERGER, M.D., Montreal.

**The Sixth Sense: An Inquiry into Extrasensory Perception,** by Rosalind Heywood, Chatto & Windus, 1959, London.

Osler, writing with that good sense for which he is renowned, says about the relationship of chemistry, anatomy and physiology to medicine, "Only so far as they bear upon a due understanding of the phenomena of disease do these subjects form part of the medical curriculum and for us they are but a means—essential means it is true, to this end." Faced with the ever expanding curriculum of psychiatry the newcomer must often wish he could be certain that his teachers and examiners had Osler's dictum in the forefront of their minds. The psychiatrist

may reasonably ask for Mrs. Heywood's book, "What have I to do with thee?" For this is as good a short account of parapsychology as one can get and is even more readable than Tyrell's admirable Penguin published about twenty years ago on psychical research, as it was then called. Here one finds the history of the subject and much evidence about it marshalled in a brief compass.

But what has it to do with us? Of what possible interest can this be to psychiatrists? There are two very different answers, both of which must be considered. To the scientists of the mind there is no great difference between events that "really happened" and events that are believed to have happened. Witchcraft for instance, has been considered a dying religion, a Christian heresy, a political underground movement, a way of diverting public attention from current social shortcomings, manifestations of psychoses in a particular cultural setting, evidence of direct relationship with a malignant power and early experimental work in psychopharmacology. Others still hold that it is simply superstition. It is still, fortunately, available for enquiry in some parts of the world. But whatever one's opinion, witchcraft has existed for centuries. It is one of the brute facts with which we have to contend although there are still many differences of opinion about it. Parapsychology is likewise a fact and since it abutts closely on our special field of competence, it behooves us from time to time to scrutinize it and see how it relates to psychiatry.

Mrs. Heywood allows us to do this without much exertion and searching through rare and costly works. She has presented her evidence clearly and shows that many able and intelligent people have been and, even today, are strongly persuaded that communication between human beings is not necessarily restricted to those five sensory channels which we commonly use. This point of view has been held by such formidable intelligences as Kant, William James, Freud, McDougall, Morton Prince, and Gilbert Murray. It is held at present by men of such standing as the philosophers, Professors C. D. Broad and H. H. Price, the psychologists Professor Thouless and Professor Gardner Murphy, biologists such as Sir Allistair Hardy, the neurophysiologist, Sir John Eccles and that formidable polymath, Mr. Aldous Huxley.

It is at least likely that the majority of human beings entertain a friendly neutrality towards this idea. Yet one doubts whether there would be many open supporters for a discussion on parapsychology at a psychiatric meeting, even though an anonymous vote taken from the same people might yield very different results. Why should this be so? In psychiatry we use a theory of mind which crystalized about the turn of the century when the Newtonian universe was still with us and chemistry and physics still used a billiard ball atom which could be neither compressed nor divided. It is strange in a world which has changed astonishingly that our psychiatric ideas have generally remained much the same as they were about 1900. Psychoanalysts even make something of a virtue of being orthodox in these matters and never going outside the vast Freudian canon. With some notable exceptions such as Jung, psychiatric excursions into the nature of mind have remained static for almost two generations. Forty years ago it took courage to put forward Freud's views on sex, but now they are commonplace. It may be that just because the public generally is rather well disposed towards the views of the parapsychologists that we get a certain pleasure in being against the stream, feeling that this adds distinction to our craft. However, this should not prevent us from examining the evidence.

One thing is clear. Many intelligent people believe that channels of communication other than those commonly used are available, and that through these

channels a mind can become aware of the thoughts, feelings or actions of another person, or the thoughts, feelings and actions connected with a particular object. This belief is often based on personal experience or on the experience of those very close to the believer. Mrs. Heywood has collected and summarized a great variety of these happenings, running from single ones to very dramatic series of events and also to long series of experiments, some of them under highly standardized laboratory conditions.

To those who have had these personal experiences, the data presented, although interesting, is largely unnecessary—but what about those who have never had these experiences? They are in much the same situation as a color-blind man who has not yet become aware of his deficiency. He is not sure what the potter is all about and cannot decide whether his informants are deluded, frauds, or a bit of both. Yet, as Devereux (1) has shown, there is much evidence from psychiatry that telepathy is not particularly unusual in psychotherapy. Dr. Gillespie (2) at the Ciba Foundation meeting on extrasensory perception, said, "It is important to recognize that the phenomena are two-edged and involve the analysts as much as the patient. The fact that the analyst's private life and personal problems are mixed up with the phenomena makes publication difficult or impossible."

Mrs. Heywood's account of the late Professor Gilbert Murray's experiments with thought transference gives one a microscopic view of the problem which these phenomena pose. There can be no doubt about the honesty of Gilbert Murray and his co-experimenters. Furthermore, there is no doubt that their results were extremely impressive. Yet, as Mrs. Heywood emphasizes, "In the strict laboratory sense, we do not know that he did not cheat." But there are, in my opinion, more formidable questions which must be put to the whole body of parapsychological work which Mrs. Heywood hardly raises. Indeed, she falls into the same trap which has been sprung in many other sciences. Dr. Wasserman (3) at the same Ciba Foundation meeting, seems to have been among the first to recognize that many of the difficulties encountered in parapsychology do not arise either from the infrequency of the phenomena, or because they are not often repeatable under controlled conditions. These are common objections about which parapsychologists and their critics are almost equally vocal. Many sciences face problems of this sort. Wilfrid Trotter, in one of his luminous essays, notes that there are sciences like physics and chemistry which have been largely built on direct experiment, while in others such as geology, meteorology and astronomy, this is obviously impossible and experiment can only be by small scale model. The problems that face parapsychology arise from something very different. Paucity of the theory, which impairs both direct experiment and the use of small scale models, and in addition makes the information already available, much less useful.

It is, for instance, remarkable, considering what an ideal subject Gilbert Murray was, how little his strange gift was enquired into. One's impression is that neither he nor anyone else put questions about his ability which could be answered. Parapsychology then has a huge amount of data almost untouched by organising hypotheses of a scientific sort. Here, of course, it closely resembles psychiatry.

The astrophysicists who have for long been among the aristocracy of science, deal with orders of sheer unlikelihood which make both psychiatry and parapsychology seem pretty mundane. That minds might not be as discreet as we have supposed them to be is a commonplace compared with the vigorously

disputed notion that hydrogen might be formed from nothing in the interstices of space. Or that the universe ebbs and flows between infinite concentration and infinite dispersion. At a recent meeting shortly before the discovery of anti matter, Nils Bohr (4), commenting on the new Pauli-Heisenberg theory of elementary particles, said, "We are all agreed that your theory is crazy. The question which divides us is whether it is crazy enough to have a chance of being correct." My own feeling is that it is not crazy enough.<sup>11</sup>

We cannot be indifferent to theoretical developments in psychology wherever they may occur. One of the first references to Freud's work in the English literature was in that classic of parapsychology, "Human Personality and its Survival after Bodily Death." In the second issue of the International Journal of Parapsychology, Dr. Jan Ehrenwald, a psychoanalyst, discusses what he calls "non-Euclidean models of personality", which is a move in the direction which Dr. Wasserman, himself a mathematician, felt might prove fruitful.

The psychiatrist, busy in his clinical work, may be disinclined to believe that parapsychology could possibly have much bearing "upon" a due understanding of the phenomena of disease". But a careful reading of Mrs. Heywood's book will give him occasion to pause. He will find that the first recorded census of hallucinations, for instance, was done in the 1880's by the British Society for Psychical Research. Perhaps at the end he will be reminded of the comment which John Wesley made in 1764 on Mr. Baxter's book on apparitions, "How hard it is to keep the middle way! Not to believe too little or too much!" Incredulity and gullibility alike are comfortable but sluggish inhabitants of the mind. In psychiatry we need most what is most painful to sustain, an enquiring doubt, an active suspension of judgment.

H. OSMOND, Weyburn, Sask.

### References

1. Devereaux, G. (Ed.) *Psychoanalysis and the Occult*.
2. Gillespie W. H. In "Extrasensory Perception" CIBA Foundation Symposium J & A Churchill, London, 1956.
3. Wasserman, G. D. Ditto.
4. Dyson, F. J. Innayahons in Physics. Scientific American, Sept. 1958.

**And the poor get children**, by L. Rainwater and K. K. Weinstein. Quadrangle Books Inc., Chicago, \$3.95, 202 pages.

With the sub-title of "Sex, Contraception and family planning in the working class", there is more than a breath of succinct Victorianism in the naming of this book which is taken from the quotation "the rich get richer and the poor get children".

The authors, whose research is based on the work of the Planned Parenthood Federation of America, attempt to find out what working class husbands and wives think about the practice of contraception in family life.

On the whole it would appear that the thoughts of the poor are not very different from those of others in more prosperous circumstances except in the drab greyness of their approach to the whole subject which, if the testimony in this book reflects the general trend, is relieved but seldom by that greatness of spirit which occasionally illuminates the process of human life.

One wonders what has happened to the lusty kind of living which must have been familiar to the parents and grandparents of the subjects of this book in the days of massive and dramatic immigration to the United States. Would their comments have been very different? Perhaps not, for the ways of people, even

allowing for the introduction and acceptance of contraception, are not greatly changed from generation to generation.

Lord Kitchener, while watching a battalion of the citizen armies of 1915 bathing in the sea, is said to have remarked "I really had no idea the working classes had such white skins". One cannot help the feeling that this idea, a flash of revelation to that Olympian observer, conveyed more in its sardonic humour than would a juggernaut of statistical research.

T. E. APPLETON, Ottawa.

**Reports and Symposiums**, Group for the Advancement of Psychiatry, 104, East 25th Street, New York 10. Vol. 3. 1960.

This volume contains eight Reports and four Symposiums published by the Group for the Advancement of Psychiatry during the period 1 June 1956 to 31 May 1959. It is difficult to delineate the audience for which it is intended. The contents are too heterogeneous to attract a reader to read through the whole book, and presumably those interested in specific areas have read the reports as they appeared. The main usefulness of this collection will be for reference purposes. The individual reports vary considerably in general interest, comprehensiveness and usefulness. Several of them are authoritative reviews of their subject with excellent bibliographies. Topics covered include psychiatric research methods, mental health education, forceful indoctrination, epilepsy, school desegregation, child psychiatry, leisure-time activities, teaching of psychiatry, religion and psychiatry, psychological problems of working abroad.

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